HEALTH INSURANCE

MARKETPLACE 2023

Provider Manual

Provider Services
Local: 713.295.6704
Toll Free: 1.855.315.5386
Website: Provider.CommunityHealthChoice.org

Health Insurance Marketplace

COMMUNITY HEALTH CHOICE

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QUICK REFERENCE INFORMATION

Provider Services	For general questions or to submit your updates: Phone: 713.295.6704 Toll Free: 1.855.315.5386 CommunityHealthChoice.org E-mail: ProviderWebInquiries@CommunityHealthChoice.org Or contact your Provider Engagement Representative.
Community Health Choice Website	CommunityHealthChoice.org https://Provider.CommunityHealthChoice.org/ The site offers general information and various tools that are helpful to the Provider such as: • Prior Authorization Requirements • Provider Manual • Provider Directories • Provider Newsletters • Downloadable Forms
Claims Inquiries or Adjudication	CommunityHealthChoice.org Phone: 713.295.6704 Toll Free: 1.888.760.2600 Community Health Choice will accommodate three claims per call. Unlimited inquiries on website
Utilization Management (Medical)	Phone: 713.295.6704 Fax: 713.295.7019
Utilization Management (Behavioral Health)	Phone: 1.855.539.5881 Fax: 713.576.0932 (inpatient) Fax: 713.576.0930 (outpatient) Fax: 713.848.6941 (inpatient discharge)
Care Management/Disease Management: Asthma, Diabetes, Congestive Heart Failure, High-Risk Pregnancy	Phone: 832.CHC.CARE (832.242.2273) Fax: 713.295.7028 Toll-free fax to 844.247.4300 E-mail: CMCoordinators@CommunityHealthChoice.org
Case Management: Behavioral Health	Phone: 713.295.6704 Fax: 713.576.0933 E-mail: BHCasemanagementreferrals@CommunityHealthChoice.org
Report High Risk Pregnancy or Sick Newborn	Phone: 713.295.2303 Toll Free: 1.888.760.2600 Fax: 713.295.7028
Peer-to-Peer Discussions	Phone: 713.295.2319

Mailed Claims	Community Health Choice (Effective: January 1, 2023) Attn: Claims P.O. Box 981839 El Paso, TX 79998-1839
Refund Lockbox	Community Health Choice P.O. Box 4626 Houston, TX 77210-4626
Electronic Claims	Submit directly through Community Health Choice's online claims portal: CommunityHealthChoice.org > Provider Tools > Claims Center Payer ID: **60495** Change HealthCare Solutions, Inc. (formerly Emdeon/Relay Health): 1.877.469.3263
Adverse Determination and Appeals (Medical)	Community Health Choice Attn: Medical Appeals 4888 Loop Central Dr. Suite 600 Houston, TX 77081 Fax: 713.576.0937 (Standard Medical Appeals) All appeals must be in writing and accompanied by medical records.
Adverse Determination and Appeals (Behavioral Health)	Community Health Choice Attn: Behavioral Health Appeals P.O. Box 301411 Houston, TX 77230 Fax: 713.576.0934 (Behavioral Health Standard Appeal Requests) Fax: 713.576.0935 (Behavioral Health Expedited Appeal Requests) All appeals must be in writing and accompanied by medical records.
Behavioral Health	Toll Free: 1.855.539.5881
Lab	Members can go to any of these preferred laboratories: • Clinical Pathology Laboratories, Inc. • LabCorp • Quest Diagnostics
Pharmacy	Navitus Health Solutions 1.866.333.2757 | Navitus.com
Vision Services	Envolve Vision Customer Service (Member Eligibility and Claims Inquiries): 1.844.686.4358 Network Management (Provider Participation): 1.800.531.2818
File a Complaint	Community Health Choice Attn: Service Improvement 4888 Loop Central Dr. Suite 600 Houston, TX 77081 ServiceImprovement@CommunityHealthChoice.org

Introduction

About Community Health Choice

Community Health Choice (Community) is a non-profit Managed Care Organization (MCO) licensed by the Texas Department of Insurance (TDI). Through its network medical and behavioral health Providers and acute/pediatric/behavioral health hospitals, Community serves more than 380,000 Members with the following programs:

- Medicaid State of Texas Access Reform (STAR) Program for low-income children and pregnant women
- Children's Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR
- Marketplace plans for individuals, including subsidized plans for low-income families
- Medicare Advantage Dual Special Needs plan (HMO D-SNP) for people with both Medicare and Medicaid.
- Administrator for collaborative safety net projects such as the Delivery System Reform Incentive Payment (DSRIP) and Network Access Improvement Program (NAIP), among others

Community holds *Health Plan with Health Insurance Marketplace* accreditation by URAC.

An affiliate of the Harris Health System, Community is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.

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.

Vision Statement

Our vision is a healthy life for every Texan.

Mission Statement

Our mission is to improve the health and well-being of underserved Texans by opening doors to healthcare and health related social services.

Values Statement

Our team members of Community are trustworthy, caring individuals who work collaboratively with our Members, Providers, and community partners. We are courageous, creative, and responsive as we serve Members and the community.

Marketplace Service Area

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, quick reference guides, 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 services
- Submitting corrected claims
- Appealing adverse determinations

Material in this Provider Manual is subject to change. The most recent information is also available on our website at CommunityHealthChoice.org. Updates and new services may be added periodically to the Provider Manual as required by law, rule or regulation. Community will post the revised information on our website 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 website 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) shall govern.

Code of Ethics

Community is committed to providing access to a quality network and healthcare delivery systems that provide health care in a manner that preserves the dignity, privacy, and autonomy of the Members.
To achieve this goal, Community Network Providers shall:

- Treat all Members with respect and courtesy.
- Respond promptly to Members' questions and concerns.
- 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 Quality Improvement activities
- Allow Community to use their performance data
- Providers 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 website at CommunityHealthChoice.org.

Provider Participation Criteria

Community maintains Provider participation criteria for physicians, facility, ancillary, and urgent care providers.

Physician Participation Criteria

The following participation criteria applies to all physicians participating in Community's Provider network(s), subject to exception based on Community's sole discretion, e.g., unique geographic or demographic circumstances or specific Member access and availability needs. Please be aware of the Physician Participation Criteria in the event you are in the process of recruiting additional practitioners to your practice.

Community may exclude physicians from participation if they do not meet the physician participation criteria.

Criteria Type	Criteria	Additional Notes
Regulatory	Participation in Wellness	Applies to PCP Providers only
	Medicare Number (required)	Does not apply to pediatric or OB/GYN Providers
	Answering Service–Access to live person or callback from live person within 30 minutes of call	
	Not currently on Government Exclusion List	

Administrative	Internet access–office/patient care setting	
	Facsimile	
	Hospital privileges at participating hospital or surgery center	Or advanced approval of acceptable coverage (e.g., hospitalist or designation)
	Submission of authorization requests via Provider Portal	
	EDI–Electronic Claims Submission	Through existing clearinghouse partnerships
	EDI–Electronic Funds Transfer	
	EDI–Electronic Remittance Advice	
	Adherence to HIPAA Standard Transactions	
	Participation in CAQH program	
	Electronic Medical Record (EMR)	

Ancillary/Facility Participation Criteria

The following Participation Criteria applies to all ancillary Providers in Community's Provider network(s), subject to exception based on Community's sole discretion (e.g., unique geographic or demographic circumstances or specific Member access and availability needs).

Criteria Type	Criteria	Additional Notes
Administrative	Valid Medicare number (required)	
	At least one line dedicated for facsimile	
	Submission of authorization requests via Provider Portal	
	EDI–Electronic Claims Submission	Through existing clearinghouse partnerships
	EDI–Electronic Remittance Advice	
	EDI–Electronic Funds Transfer	
	Electronic Medical Record (EMR)	
Regulatory	Answering Service– Access to live person or callback from live person within 30 minutes of call	
	According to 45CFR§156.1110, Establishment of Patient Safety Standards, a health plan (MCO) contracted with hospitals must meet the standards as described below: ***Patient safety standards***. A QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital, as defined in section 1861(e) of the Act: For plan years beginning before January 1, 2017, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for: (1) A quality assessment and performance improvement program as specified in 42 CFR 482.21; and (2) Discharge planning as specified in 42 CFR 482.43.	Applies to hospitals only

Urgent Care Participation Criteria

The following Participation Criteria applies to all urgent care Providers in Community's Provider network(s), subject to exception based on Community's sole discretion (e.g., unique geographic or demographic circumstances or specific Member access and availability needs).

Criteria	Additional Notes
Has valid Medicare number	
Internet access–office/patient care setting	
Facsimile	
Electronic medical record (EMR)	
Electronic submission of prescriptions (e-Prescribe)	
Answering Service–Access to live person or callback from live person within 30 minutes of call	
EDI–Electronic Claims Submission	Through existing clearinghouse partnerships
EDI–Electronic Funds Transfer	
EDI–Electronic Remittance Advice	
Visit summary to PCP within 24 hours or next business day	
Adherence to HIPAA Standard Transactions	
Accreditation–Urgent Care Association of America (UCAOA)	
Certification–Certified Urgent Care (CUC) Program	
Electronic medical records	
Electronic submission of prescriptions (e-Prescribe)	
Onsite services (lab, x-ray, etc.)	

Provider Credentialing and Recredentialing

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 processes 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 up to 90 days from receipt of a completed application packet.

If you are part of a group that already participates with Community Health Choice, you can request expedited credentialing, which will allow you to serve Members on a provisional basis while your credentialing application is pending. To qualify for expedited credentialing per Sec. 1452 of the Texas Insurance Code (TIC), you must meet all of the following criteria:

- Be a member of an established healthcare provider group that has a current contract in force with Community
- Be a provider type specified in TIC 1452
- Be licensed by the State of Texas, and in good standing with the appropriate state licensing Board
- Agree to comply with the terms of the contract
- Submit all documentation and information required to begin the credentialing process

Important: Please ensure that your credentials and information are current with CAQH to avoid any delays in the credentialing or recredentialing process.

CAQH: https://www.caqh.org/solutions/caqh-proview-providers-and-practice-managers

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 to contact you to supplement, clarify or confirm certain information submitted on your CAQH application.

Provider Portal

Community's online Provider Portal offers secure, 24-hour-a-day, 7-days-a-week access to online tools and services. Providers can submit claims and view claim status, as well as Member eligibility, benefits, and the status of pre-authorizations. To access the Provider Portal, visit CommunityHealthChoice.org > Provider > Register Today. Complete the Secure Access Application and send it to Community. We will process your form and provide your login credentials within three business days.

Forms for Providers

Please visit our Provider website at https://provider.communityhealthchoice.org for all Community Health Choice forms. You may download them for your use as needed.

Provider Roles and Responsibilities

Selecting a Primary Care Physician or Provider (PCP)

Community requires that Members select a Primary Care Provider (PCP) for themselves and for each covered dependent. 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 Centers
3. Rural Health Clinics
4. Specialty physicians (for Members with a chronic, disabling or life-threatening illness)
5. 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. Coordinating utilization of services and monitoring the progress of care to facilitate the return to the PCP as soon as medically appropriate,
4. 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),
5. Complying with Quality Improvement Programs, which may include periodic chart reviews.
6. Maintaining an open panel for Membership. If needing to be changed, PCP must notify Community.
7. Cooperating with Community Health Choice's Care Management Program by providing clinical information when necessary and participating in care plan development for Community Health Choice Members with chronic diseases.

Provider Responsibilities

- Contact Community to verify Member eligibility prior to providing covered services
- Maintain confidentiality of Personal Health Information (PHI) for community Members and adhere to all HIPAA requirements
- 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 recredentialing 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 ten 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 Providers agree to file claims and encounter information with Community even if the Provider believes or knows there is a third-party liability.
- Only bill subscribers for copayments, coinsurance, and deductibles, where applicable.
- Providers 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 Quality Improvement 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 "Primary Care Provider"

Members with disabilities, special health care needs, and chronic or complex conditions may make a request to Community to use a specialist as the Member's PCP. The specialist must either be: 1) a currently credentialed and contracted provider in Community's network; or 2) be eligible for credentialing according to Community's Credentialing Policies and Procedures. The specialist must agree to perform all PCP duties required in the contract including meeting the after hour coverage requirements and other access standards. PCP duties must be within the scope of the specialist's license. The member must have a demonstrated medical need to utilize a specialist as the PCP. Medical need will be determined on a case-by-case basis and will include but not be limited to the following areas:

a. Terminal cancer
b. HIV/AIDS
c. Progressive neurological diseases
d. Members in hospice care

The specialist must be approved by the Medical Director. The specialist must sign a statement stating that he or she is willing to accept responsibility to serve as the Member's PCP and accept Community's reimbursement for non-specialty, PCP-related services.

The Member must sign a statement indicating consent for the specialist to serve as a Primary Care Physician. The Medical Director of Community 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, not later than thirty (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.

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.

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.

Community requires prior authorization for certain services. Visit CommunityHealthChoice.org for a list of services that require prior authorization.

To authorize services:

- Call 713.295.6704
- Fax a request to 713.295.7019
- Submit an authorization at CommunityHealthChoice.org

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.

To verify eligibility:

- Complete a *Community Secure Access Application* to become an authorized user of the provider portal at CommunityHealthChoice.org. Call Provider Services for more information.
- Call Community Member Services at 713.295.6704.

Referral to Network Facilities and Contractors

To authorize services:

- Call 713.295.6704
- Fax a request to 713.295.7019
- Submit an authorization at CommunityHealthChoice.org

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 CommunityHealthChoice.org.

In most instances, there are participating Providers available to provide any and all covered services necessary to meet a Member's overall healthcare needs. If a participating Provider determines 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 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 recredentialing decision, Community reserves the right to make changes to the list of participating Providers at any time.

Second Opinions

A Member, parent, legally appointed representative (LAR) or the Member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, surgery options or other treatment of a health condition. The second opinion shall be provided at no cost to the Member.

The second opinion must be obtained from a network Provider. If an in-network Provider is not available, Community will approve referral to an out-of-network Provider for the second opinion at no cost to the Member. Upon request, Community will provide assistance to the Member or requesting PCP/specialist to obtain the second opinion.

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 Network Management Department in writing to report any of the following changes:

- Name
- DPS
- Address
- Permit to practice
- Office hours
- Group affiliation
- Professional liability insurance coverage
- Limits placed on practice
- Status of hospital admission privileges
- Specialty change
- Opening/closing of panel
- Tax ID number
- Other information that may affect current contracting relationship
- Addition of any practice and closure of address
- Contract status change
- Patient age limitations
- New Provider, Physician Assistant, and Nurse Practitioner in practice
- NPI number

- Telephone number
- DEA number
- Medicare Provider number
- 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.
Mail notification of changes to:

Community Health Choice
Attn: Network Management
4888 Loop Central Dr. Suite 600
Houston, TX 77081
Fax: 713.295.7058

E-mail: CHC.Contracting@CommunityHealthChoice.org

NPI Registry

Providers should review their information on the CMS National Plan and Provider Enumeration System (NPPES) NPI Registry regularly and update their information as needed. Website: https://nppes.cms.hhs.gov/#/

Plan Termination

Providers who elect to terminate Community participation must provide a 90-day written notice to Community by fax, email or certified letter. 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 transfer patients efficiently to another PCP. Physicians are requested to continue care in progress until all Members can be successfully transferred to a new PCP.

Appointment Availability Standards

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

Service	Appointment Availability
Emergent	Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities
Urgent	Must be provided within 24 hours, including urgent specialty care and behavioral health services
Primary Routine Care	Must be provided within 14 days, including behavioral health
Specialty Routine Care	Must be provided within 21 days
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days

Prenatal Care	• Initial appointment must be provided within 14 days for non-high-risk pregnancies. • For high-risk pregnancies or new Members in the third trimester, initial appointment must be provided within five days or immediately. • Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.
Preventive Care Physical/Wellness Exams	• Newborns (less than 6 months of age): Within 14 days • Children (6 months to 20 years): Within 2 months • Adults (21 years and older): Within 90 days • New Members: Within 90 days of enrollment

Emergent/Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), 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:

- 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 impairments to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time to safely transfer a Member who is pregnant and having contractions to another hospital before delivery, or if a hospital transfer might pose a threat to the health or safety of the woman or the unborn child
- 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.

Urgent Condition: A health condition, including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's Primary Care Provider or designee to prevent serious deterioration of the Member's condition or health.

Routine or Preventive (Non-Emergent): 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.

Primary Care Provider 24-Hour Availability

PCPs are required to provide 24-hour availability, seven days a week for Community Members. 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 state that Primary Care Providers must "be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, seven days a week." Additionally, the contracts state that Primary Care Providers must "maintain one of the following to receive calls from Members after normal business hours":

Acceptable after-hours coverage

1. The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;

2. 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 Member 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; and

3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical Provider, who can return the call within 30 minutes.

Unacceptable after-hours coverage

1. The office telephone is only answered during office hours;
2. The office telephone is answered after-hours by a recording that tells Members to leave a message;
3. The office telephone is answered after-hours by a recording that directs Members to go to an emergency room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

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. All medical records must be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of patient records. Provider must retain medical records for a period of ten years following termination of the Provider's contract with Community Health Choice or longer as mandated by any applicable State or federal law.

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. The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws. Medical records, 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 that 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 health care relating to the provision of health care 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 that may be affecting physical health care 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 that 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 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.

Member Rights and Responsibilities

Effective healthcare 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, dignity, privacy, confidentiality, and nondiscrimination.
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.
7. Members have the responsibility to:
    - Learn and understand each right they have and ask for help when they need it
    - Follow all healthcare plan rules and policies
    - Treat all doctors and healthcare 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.

Behavioral Health

Behavioral health services are covered services for the treatment of mental health and emotional disorders, as well as substance abuse disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications and/or ICD-10 classification systems. Those services include treatment at inpatient, outpatient, and divisionary levels of care.

An emergency behavioral health condition is any condition, without regard to the nature or cause of the condition that 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 health care
- 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
- Not experimental or investigative
- Not primarily for the convenience of the Member or Provider

The mental health priority populations are those individuals served by The Harris Center. 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.

Behavioral Health Appointment Accessibility Standards	
Emergent/Life Threatening	Immediate
Urgent	Within 24 hours
Routine Primary Care	Within 14 days of the request
Initial Outpatient Behavioral Health	Within 14 days
Specialty Routine	Within 21 days
Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission	Within 7 days from the date of discharge

Primary Care Provider Requirements for Behavioral Health

Community PCPs must screen, evaluate, refer, and/or treat any behavioral health problems and disorders. 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.

Providers can call Community toll-free 1.877.343.3108 to obtain assistance in identifying an appropriate contracted Behavioral Health Provider for their patient. Members can call the Crisis Line 24 hours a day, seven days a week toll-free at 1.877.343.3108.

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.

Self-Referral

Community Members may self-refer to any in-network Behavioral Health Provider. Community Members can also call Community at 713.295.6704 regarding how and where to obtain behavioral health services. No prior approval from the PCP is required.

To refer Members:

- Call Provider Services at 713.295.6704.
- Fax referral information to our dedicated behavioral health faxes at 713.576.0932 (inpatient) or 713.576.0930 (outpatient).

Behavioral Health Services

Community's Provider Network makes available behavioral health services for the treatment of mental health, as well as drug and alcohol issues that include:

- Psychiatric assessment and referral services
- Individual, family, and group counseling
- Acute inpatient hospitalization
- Short-term residential
- Partial hospitalization for mental health conditions
- Intensive outpatient programs (value-added benefit)
- Medication evaluation and monitoring
- Referral for other community services
- Case management
- Attention Deficit Hyperactivity Disorder (ADHD) services
-
- Targeted Case Management
- Mental Health Rehabilitative Services

Coordination between Behavioral Health and Physical Health Services

PCPs and Behavioral Health Providers must work with Community to be in compliance with parity and comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations.

Behavioral Health Providers should send initial and quarterly, or more frequently if clinically indicated, summary reports of a Member's behavioral health status to the Primary Care Provider. Member or the Member's Legally Authorized Representative (LAR) must provide consent for the release of such information to the PCP.

Behavioral Health Providers may only provide physical healthcare services if they are licensed to do so.

Medical Records Documentation

Community-contracted Behavioral Health Providers must use the current version of the DSM. This information, as well as assessment/outcome information, is to be documented in the Member's treatment record.

Consent for Disclosure of Information

Information concerning the diagnosis, evaluation or treatment of a Community Member by a person licensed or certified to perform the diagnosis, evaluation or treatment of any medical, mental or emotional disorder or drug abuse is normally confidential information that the Provider may disclose only to authorized persons. Family planning information is particularly sensitive, and confidentiality must be assured for all clients, especially minors. Client information may only be released after the client provides a written release of information.

Assessment Instruments for Behavioral Health: PCP Toolkit

Community developed a comprehensive PCP Toolkit for Primary Care Providers to assist in identifying and treating behavioral health issues. It includes information on the most common behavioral health issues, including guidelines for diagnosis and treatment, fact sheets for Members, and assessment tools. Delivering behavioral health services in a primary care setting can help reduce the stigma associated with mental health diagnoses. Primary care settings are also becoming the first line of identification for behavioral health issues, and Primary Care Providers are the center of care for many patients who have both physical and

behavioral health disorders. To support Primary Care Providers, 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 Primary Care Providers can help their patients understand their diagnoses and take the right steps to become and stay healthy.

Conditions included in the toolkit:

- ADHD in Children and Adults
- Alcohol and substance abuse/addiction
- Anxiety
- Autism
- Bipolar Disorder
- Eating disorders
- Major Depression
- Opiates
- PTSD
- Schizophrenia

Providers may access the PCP Toolkit online at CommunityHealthChoice.org.

Inpatient Discharge Follow-Up and Missed Appointment Procedures

Community Members receiving inpatient psychiatric services must be scheduled for outpatient treatment prior to discharge. They must receive outpatient treatment within seven days from the date of discharge and a follow-up appointment within 30 days after hospitalization for mental illness. Behavioral health aftercare services can be provided by psychiatrists, psychologists, licensed therapists or alternative care services as appropriate for the individual Member. Missed appointments should be rescheduled within 24 hours.

Members with a behavioral health diagnosis are also monitored for readmission to an inpatient facility. Results of these reports and focused studies are available to Providers upon request.

Physical Health Lab/Ancillary Tests

Behavioral health Providers are required to refer Members with physical health problems to their PCP for treatment.

Providers should utilize participating laboratory vendors to provide analysis of labs related to outpatient psychiatric medication management.

Behavioral Health Focus Studies and Utilization Management Reporting Requirements

Community is contractually required to inform and include all Providers in health plan quality reporting and activities. Behavioral Health Providers are required to participate in the following UM/QI Plan:

- UM Reports: Based on modified HEDIS measures (performed on 100 percent of submitted claims/encounters) the data is obtained through medical records data and Provider and Member surveys.
- Member Records: Randomly selected for auditing
- Encounter/Claims Data: Submitted on CMS 1500 or UB 04 format. It is critical that these claims be filed clearly and correctly.
- Provider Surveys: Please complete and return
- Member Surveys: Random number of Members selected to complete
- Provider Profiles: Community will complete and make available to the Provider

Pharmacy

Pharmacy benefits for Community Members are administered by Navitus Health Solutions, a pharmacy benefit management company. For questions related to pharmacy benefits, including participating pharmacies, formulary, preferred drugs, billing, prescription overrides, prior authorizations, quantity limits or formulary exceptions, please call Navitus Customer Care toll-free at 1.877.908.6023 or visit Navitus.com. The Navitus formulary adheres to a preferred drug list and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called the Pharmacy and Therapeutics (P&T) Committee.

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)

Some medications do require prior authorization. More information about which medications require prior authorization is available on 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 turnaround time 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 a 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 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 website at Navitus.com. The formulary list is available online at CommunityHealthChoice.org.

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.

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.

Clinical Practice Guidelines

As part of its quality-improvement process, Community develops 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 according to the 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)
- Other related guidelines from a public resource for evidence-based clinical practice guidelines like the National Guidelines Clearinghouse (NGC). NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services AHRQ.gov.

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 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 website.

Authorizations for Health Services

Prior Authorization

Prior authorization (sometimes referred to as pre-certification or pre-notification) determines whether non-emergent medical treatment is medically necessary, is compatible with the diagnosis, if the Member has benefits, and if the requested services are to be provided in the appropriate setting.

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 Health Choice will adjudicate and process claims according to the terms and conditions of the Provider's contract with Community Health Choice.

Services Requiring Authorization

The list of services requiring prior authorization is on the Prior Authorization Guide located on the Provider Portal, at CommunityHealthChoice.org > For Providers > Provider Tools > Authorization/Notifications. The guide may not include all

services that require or do not require prior authorization. Please call 713.295.6704 for further information if you are unsure of prior authorization requirements. The list of services is subject to change and will be updated as required.

Clinical Practice Guidelines

Clinical Practice Guidelines are reviewed by the chief medical officer and/or the medical director(s) and Medical Care Management Committee at minimum annually and updated at least every two years. Clinical Practice Guidelines address the following domains:

- Disease Management
- Complex Case Management
- Two behavioral health conditions, one of which addresses children and adolescents
- Preventive Health Guidelines for the following:
  - Perinatal care
  - Care for children up to 24 months old
  - Care for children 2 – 19 years old
  - Care for adults 20 – 64 years old
  - Care for adults 65 years and older

Providers are informed about availability of the guidelines through various methods including Provider newsletters, Community Health Choice's website, Provider manual, Provider services staff, and as needed through faxes.

InterQual

Community utilizes InterQual Criteria for evidence-based clinical guidelines for medical and behavioral health services.

InterQual is a nationally recognized utilization management (UM) tool that will provide us with reliable, evidence-based clinical decision support. InterQual is trusted by more than 4,600 hospitals and facilities and more than 280 managed-care organizations. InterQual criteria is also continuously updated with the most recent evidence and clinical standards, using a wide variety of medical specialists to manage and validate their medical criteria sets.

InterQual is known for its clinical integrity, innovative technology and service excellence. We are confident it will help us continue to meet the following objectives:

- Assure optimal and consistent utilization management decision-making
- Support the appropriateness of care
- Manage medical costs
- Foster appropriate utilization of resources

Prior Authorization Requests

Community Health Choice accepts Community Health Choice's Preferred Prior Authorization Form as well as the Texas Standard Prior Authorization Form. Submit requests for authorization via the Provider Portal or via fax to 713.295.7019. To avoid delays, include supporting documentation and clinical notes to support your request for authorization of services.

Community Health Choice strives to provide excellent service to our entire network and will continue to work toward improving your experience with us. Providers will soon receive additional information about a solution in our Provider Portal with benefits including:

- Easy submission of prior authorization requests via the Provider Portal,
- Access to an online catalogue of procedures that require Prior Authorization, and
- Visibility of authorization status.

Providers should submit prior authorization requests:

1. At least five days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services

3. Within 24 hours of any inpatient admission, including emergent inpatient admissions.
4. At least five days prior to the scheduled start of home health services, except those enrollees needing home health services after hospital discharge.

Essential Information

Providers must submit the Prior Authorization Request Form. The form must include the following information to initiate the prior authorization review process:

- Member name
- Member date of birth
- Member number or Medicaid number
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Rendering provider's name
- Rendering provider's National Provider Identifier (NPI)
- Service requested:
    - Current Procedural Terminology (CPT),
    - Healthcare Common Procedure Coding System (HCPCS), or
    - Current Dental Terminology (CDT)
- Service requested start and end date(s)
- Quantity of service units requested based on the CPT, HCPCS, or CDT requested

Please note any prior authorization requests missing essential information will not be processed and a new request will need to be submitted.

Supporting Clinical Documentation

Providers will find a list or description of any supporting documentation or other documentation necessary to obtain prior authorization for a specified service at provider.communityhealthchoice.org/resources/prior-authorization-information/.

Lack of Information

When Community receives a request for prior authorization and the request does not contain complete clinical documentation and/or information:

- Community will notify the Member by letter that an authorization request was received, but cannot be acted upon until Community receives the missing documentation/information from the requesting Provider. The letter will include the following information:
    - A statement that Community has reviewed the PA request and is unable to make a decision about the requested services without the submission of additional information.
    - A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
    - An applicable timeline for the provider to submit the missing information.
    - Information on the manner through which a provider may contact Community.
- Community will contact Provider via fax or phone and request documentation for completion of the medical necessity review within three business days of Community's receipt of request.
- If Community does not receive the documentation/information by the end of the third business day of Community's request to the requesting Provider, the request will be submitted to the Medical Director no later than the seventh business day after receipt of request.
- Community will make a decision no later than the tenth business day after the request received date.

Failure to Obtain Prior Authorization or Referral

For any covered service rendered to, prescribed or authorized for Members by Provider in a non-emergent situation for which Community or payor requires Prior Authorization in advance of the delivery of service, and that Prior Authorization was not obtained by Provider in advance, Provider understands that Community or payor will deny Provider's claim for said covered services. In no event will Member be financially responsible for payments arising for such services, except for applicable Member expenses as may be required under a benefit plan/program.

Prior Authorization Determination Timeframes

Community issues a determination within the following timeframes according to state regulatory requirements.

Prospective Review

- Emergency Medical or Emergency Behavioral Conditions do not require prior authorization
- Urgent - As soon as possible based on the clinical situation, but no later than one business day from receipt of a request for a Utilization Management (UM) determination
- Routine - Within three business days from the receipt of a request for a UM determination
- Inpatient - Within one business day from the receipt of a request for a UM determination
- Post-hospitalization or life-threatening conditions - within one hour from the receipt of a request.

Concurrent Review

Community issues the determination for reduction or termination of a previously approved course of treatment early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs, but no longer than two business days.

Retrospective Review

Based on the Retrospective Review Policy for authorizations, if certain conditions are met Community will issue a determination, Community will issue a determination within 30 calendar days from the receipt of request for a retrospective UM determination for a service that Provider has already rendered and for which Provider has not submitted a claim. Fax requests for Retrospective Review with supporting documentation to 713.576.0937.

Peer-to-Peer

If an authorization request does not meet medical necessity, a Medical Director will review the request. Community will send a fax notification to the requesting Provider with the offer of a Peer-to-Peer. To request a Peer-to-Peer discussion, please call 713.295.2319.

Authorization for Out-of-Network Services

A PCP may request authorization for out-of-network services which cannot be provided within the Community Health Choice network. To request an out-of-network authorization, submit an Authorization Form on Community Health Choice's website CommunityHealthChoice.org or by fax to 713.295.7019. Community Health Choice's medical director will review the clinical information and either authorize or deny the services according to the availability of such services within the Community Health Choice network, presenting pertinent clinical information and medical necessity. All denials are the responsibility of the medical director.

Options for Member Non-Compliance

Contact Community Provider Services 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 PCP 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.

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 under-utilization.

Care Management

Community Health Choice defines care management/disease management as a system of coordinated healthcare interventions and communications for populations with the disease states in which Member self-care efforts are significant. A critical objective of the Disease Management program is to enhance the Member's ability to self-manage the disease through the application of prevention skills, self-monitoring, avoidance of risk behaviors, and informed decision-making related to healthcare resources.

PCPs are expected to transmit information to the Community Health Choice Care/Disease Management Department for those Community Health Choice Members who elect to participate in one of Community Health Choice's Care/Disease Management programs. Requested information will vary with each disease; they may include but are not be limited to:

- Laboratory information
- General medical records
- Pharmacologic information
- Referral notifications
- Special needs to be addressed, if any
- Demographic information

It is vital to the success of the program that the Primary Care Provider informs the Member about the program and that you are referring them. Physician support is key. Community does not require that a specific referral form be filled out to refer a Member to our Care Management/Disease Management Programs. Please indicate to which program you would like to refer the Member

(i.e. diabetes, asthma, high-risk perinatal, congestive heart failure). Include any pertinent clinical information (i.e. asthma action plan, A1c, recent notes or plan of care). Community always wants to support the plan of care or instructions provided by the physician. Once a care plan is developed with the Primary Care Provider, the care plan will be mailed to both the enrolled Member and the medical home physicians. Follow-ups to the care plan will be forwarded on a routine basis to the medical home physician.

Care Management/Disease Management and Community Health Choice Providers

Community employs a Member-centric approach to developing the most effective and successful partnerships with our Members and Providers. We count on our Primary Care Providers and specialists to provide invaluable feedback that ensures the success of our programs. Our goal is to complement rather than complicate our Providers who are treating Members in the Disease Management programs. Community makes available an integrated staff-support team from various clinical and managed-care disciplines to coordinate with the assigned Primary Care Providers and other medical Providers participating in the Member's care and help the Member achieve positive health outcomes. Through Disease Management programs, Community works with Members, their healthcare Providers, and families to assist the Member in reaching and maintaining an optimal health status that avoids costly and unnecessary services.

There are many reasons to refer Members to the Disease Management program:

- Education specific to disease via quarterly updates
- Open access to network specialists and assistance with appointments
- Coordination of ancillary services
- Individualized plan of care
- Telephonic case management
- Transportation assistance
- 24-hour help line for Members
- Programs are at no cost to the Member and they can elect to withdraw at any time

Program	Description	Criteria
High-Risk Perinatal	Targeted to moms-to-be who are high-risk and can benefit from education and support	• High-risk, history of pre-term births, multiple pregnancies or other complications
Asthma	Targeted interventions for adults, adolescents, and children with asthma	• No age limit
Diabetes	Targeted interventions for Members with Type I and Type II Diabetes	• No age limit
Behavioral Health	Targeted interventions for Members with behavioral healthcare needs and Serious and Persistent Mental Illness (SPMI).	• No age limit • Combination of complex medical and behavioral health conditions • SPMI and evidence of difficulty navigating the challenges of managing their disease state

To contact Care Management/Disease Management:

- Call 832.CHC.CARE (832.242.2273).
- Fax referrals to 713.295.7028
- Email to CMCoordinators@CommunityHealthChoice.org.

To contact Behavioral Health:

- Fax referrals to 713.576.0933
- Email to BHCasemanagementreferrals@CommunityHealthChoice.org.

Complex Case Management Program

Community offers Complex Case Management services to Members with multiple or complex conditions.

The goals of the Complex Case Management program are to help Members regain optimum health or improved functional capacity in the right setting and utilizing the right Providers in the right timeframe 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, and 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 healthcare 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, call Member services at 713.295.6704 or toll-free 1.855.315.5386.

Quality Management

Quality Improvement Program

The Quality Improvement (QI) Program's overall objectives are to maintain a quality improvement program that promotes objective and systematic measurement, monitors and evaluates services and work processes, and then implements quality improvement activities based on the outcomes. This includes but is not limited to the following areas:

- Healthcare access
- Healthcare delivery
- Contracting and contract administration
- Provider credentialing
- Peer review
- Customer service and satisfaction
- Provider service and satisfaction
- Risk minimization
- Utilization management and appeals
- Care (disease) management and complex case management
- Preventive and interventional healthcare services
- Delegation oversight and compliance

Community Health Choice performs ongoing monitoring of clinical/administrative activities to assure high quality service delivery. This is reflected in the Operations Report, which is reported at the Community's Board of Directors meetings. The Quality Optimization Committee also tracks and trends quality metrics throughout the year and reports trends and action plans.

Quality Improvement Health Services Contracting

Community Health Choice contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI program.

Community's contracts specify that practitioners and providers cooperate with Quality Improvement (QI) activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs.

Community Health Choice has the right to use performance data based upon the below citation in the contract:

Facility (P 1.28) and Provider & Ancillary (P 1.30)

> *Provider Manual. The Community document, incorporated in its entirety by reference here, containing administrative policies and procedures relating to issues such as credentialing, utilization management, claims payment, provider complaints or appeals and quality improvement.*

Community Health Choice in its sole discretion, including but not limited to quality improvement activities; such as HEDIS reporting, Provider Incentive Programs, public reporting to consumers, and potential preferred status designation.

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.

To verify Member eligibility 24 hours a day, seven days a week:

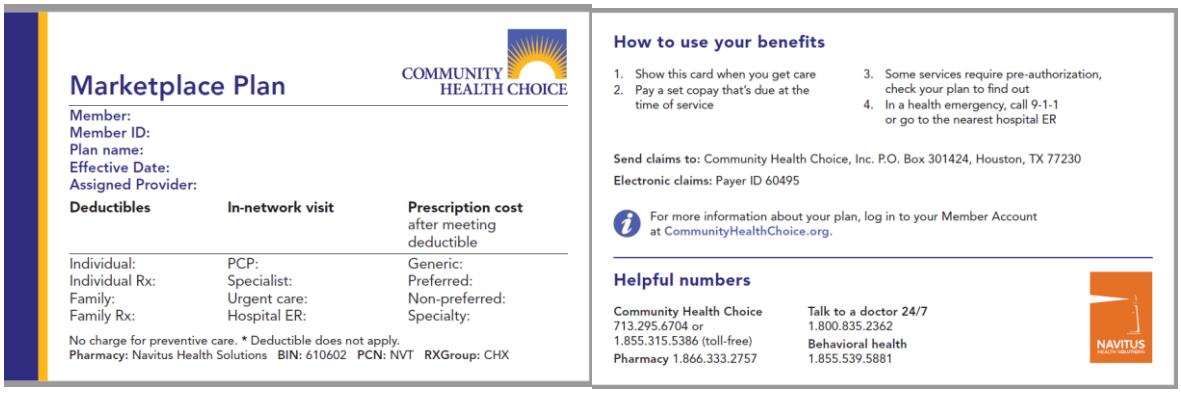
- Log in to your Provider Portal at CommunityHealthChoice.org > Member Eligibility, or complete the Community Secure Access Application to become an authorized user. Call Provider Services at 713.795.6704 to get more information.
- Call Community Provider Eligibility Services at 713.295.6704 or toll-free 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 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.



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.

Billing and Claims

Claims Filing

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.

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 Provider submit claims using retired or replaced codes, the Provider understands and agrees that Community may deny such claims until appropriately coded and resubmitted.

Requests for claims reconsideration must be submitted within 180 days from date of last disposition.

Submission of Claims

Community complies with HIPAA EDI requirements for all electronic transactions.

Go to provider.communityhealthchoice.org/resources/him-hipaa/ for a HIPAA companion guide. For additional assistance, call Community Provider Services at 713.295.6704.

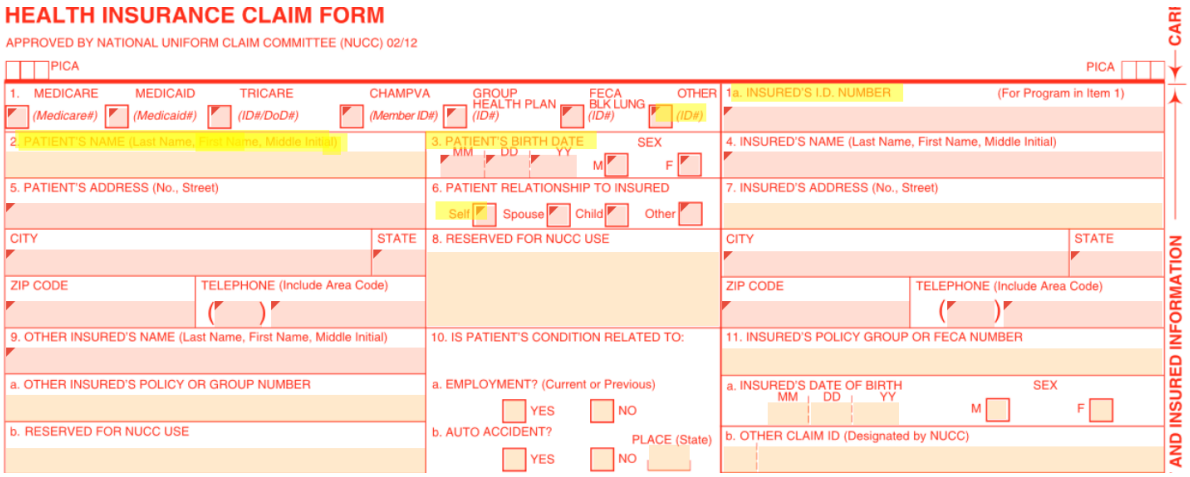
File your claims in one of two ways:

1. **Electronically**
   Community uses Change Healthcare (formerly Emdeon, formerly Relay Health).
   Our payer ID number is **60495**.

2. **Mail**
   Community Health Choice (Effective: January 1, 2023)
   Attn: Claims
   P.O. Box 981839
   El Paso, TX 79998-1839

3. **Certified mail**
   Community Health Choice
   Attn: Claims
   4888 Loop Central Dr. Suite 600
   Houston, TX 77081

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:**


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

CARI

AND INSURED INFORMATION

When submitting a claim:

- Complete a separate claim for each Member and each Provider.
- Allow 45 days for claims processing prior to submitting a duplicate claim.

When submitting a replacement claim:

- If your claim is denied because it did not contain critical claims elements required for adjudication of clean claims or you did not submit as indicated above, you may **submit your corrected paper or electronic 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 at CommunityHealthChoice.org 30 days after the submission of a clean claim.

Adjudication of Claims

Community utilizes CMS, state, and/or other nationally recognized claims and payment processing policies, procedures, and guidelines, which may include claim and code audit and edit determinations and other claims logic as may be implemented by Community or payor to process claims efficiently and provide accurate reimbursement.

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 CMS.gov. Under the rules of the Medicare Program, the Provider is paid the lower of its billed charges or the published Medicare rate. Please refer to your contract with Community for specific contractual provisions and reimbursement rates.

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. Please refer to your contract with Community Health Choice for specific contractual provisions and reimbursement rates.

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

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 traveling 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.

Clean Claims

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.

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.

Required Information for CMS 1500 and UB-04 Claims

Forms must include the following information (HIPAA-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Total charge
- Billing Provider's taxonomy codes
- COB/other insurance information
- Any other state-required data
- Date of service
- Place of service
- Diagnosis pointers
- CPT-4 codes/HCPCS procedure codes
- NDC codes
- NPI of rendering Provider
- Authorization/precertification or copy of number
- Provider's name according to the contract
- Days or units
- Modifiers
- Itemized charges
- Provider's tax ID number
- NPI of billing Provider
- Rendering Provider taxonomy codes
- Name of referring physician

CLIA

The CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. Community will deny claims for CLIA-waived lab services if the Provider does not have a valid CLIA certification on file with Community.

Rendering Provider Requirement

Community requires all professional and institutional claims to include the Rendering Provider NPI for all claims submitted. Community will deny claims if the Rendering Provider NPI is not present on the claim.

Claims Payment

Community offers payment solutions that provide innovative options for Providers to receive payments. Community partnered with Change Healthcare and ECHO Health, Inc. to provide these new electronic payment methods. Below we have outlined the payment options and any action items needed by your office:

1. **Virtual Card Services**–If ECHO does not have a documented choice of payment for you, the default method of payment will be virtual card rather than a paper check. Virtual cards allow your office to process payments as credit card transactions and are generally received 7-10 days earlier than paper checks since there are no print or mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction, your Explanation of Payment (EOP), and an instruction page for processing. Once you receive the virtual card number, you simply enter the code into your office's credit card terminal to process payment as a regular card transaction. To avoid delays, please process the card or notify

Change Healthcare/ECHO Health of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship. **NO ACTION IS NECESSARY to start receiving Virtual Credit Card payments.**

2. **EFT/ACH**–Setting up an electronic fund transfer (EFT) is a fast and reliable method to receive payment. In addition to your banking account information, you will need to provide a Change Healthcare Payment draft number and payment amount as part of the enrollment authentication. After enrolling, funds will be deposited directly into your bank account. If you are interested in receiving EFT, you can enroll by providing your banking information along with an ECHO payment draft number and payment amount to authenticate your enrollment. If you would like to sign up for EFT, you have two options:
    a. To sign-up to receive EFT through Settlement Advocate for Community only, visit https://view.echohealthinc.com/EFTERADirect/CommunityHealthChoice/index.html
    b. To sign-up to receive EFT from all payers processing payments on the Settlement Advocated platform, visit https://view.echohealthinc.com/EFTERA/efterainvitation.aspx. A fee for this service may apply.

3. **Paper Check**–To receive paper checks and paper explanation of payments, you must elect to opt out of Virtual Card Services or remove your EFT enrollment.

You can also log into ProviderPayments.com to gain online access to detailed explanation of payment for all ECHO transactions. If you wish, you can elect to receive an email notification each time Community makes a payment to you.

If you have additional questions regarding your payment options, please contact ECHO Health toll-free at 1.833.629.9725.

Electronic Remittance Advice (ERA)

An ERA is an electronic file that contains claim payment and remittance information. It is often referred to by its HIPAA transaction number, 835.

Providers can enroll to receive 835 files from their desired clearinghouse for ECHO payments.

- ECHO can supply the hard copy ANSI 835 Enrollment Form.
- Providers may access:
- https://view.echohealthinc.com/EFTERA/efterainvitation.aspx and select the option to enroll in an ERA only.

Fees are not applied to an ERA only enrollments.

If you do not receive 835 files:

- Email EDI@echohealthinc.com or
- Call Customer Service at 1.888.834.3511, Monday to Friday, 8:00 a.m. to 6:00 p.m., EST.

For additional information, please refer to the *Frequently Asked Provider Questions* booklet available in the Provider Portal at https://provider.communityhealthchoice.org/.

Overpayments

An overpayment can be identified by the Provider or Community. If Provider identifies the overpayment, please submit a completed Overpayment Refund Notification Form with all refund checks and supporting documentation. Provider can also call Provider Services at 713.295.6704 and approve a recoupment from any future payments to Provider.

If Community identifies the overpayment, a recovery letter will be sent to Provider, and Provider has 45 days to submit a refund check or appeal the refund request. If Provider does not respond within 45 days from the date of the recovery letter, then Community will begin the recoupment on any future payments.

Please mail all refund checks with a copy of the Overpayment Refund Notification Form to the following address:

Community Health Choice
Attn: Marketplace-Refund
P.O. Box 4626
Houston, TX 77210-4626

Once the Community team has reviewed the overpayment, Provider will receive a letter explaining the details of the reconciliation.

Provider Payment Reconsideration

Claims Questions/Status

Providers can check claims status, Member eligibility, and a variety of other services online via our Provider Portal. You must sign up for this service. To learn more, visit CommunityHealthChoice.org.

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

1. Contact Community Provider Services during regular business hours:

Local: 713.295.6704
Toll-free: 1.855.315.5386

2. Submit inquiries in writing to:

Community Health Choice
Attn: Provider Services
4888 Loop Central Dr. Suite 600
Houston, TX 77081

- When contacting Provider Services, 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

Provider Payment Reconsideration

Community offers Providers a payment reconsideration process. A payment reconsideration is any claim payment disagreement between the healthcare Provider and Community reason(s) including but not limited to:

- Denials for timely filing
- The failure of Community Health Choice to pay in a timely manner
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a Provider
- Inappropriate or unapproved referrals initiated by Providers (i.e., a Provider payment appeal may arise if a Provider was required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim)
- Provider medical appeals without the Member's consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

No action is required by the Member. Provider payment reconsideration do **not** include Member medical appeals. Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 713.295.6704.

Complete the Provider Payment Dispute Form which you will find on our website at https://provider.communityhealthchoice.org/resources/forms-and-guides/ and submit it along with supporting documentation to:

Community Health Choice
Attn: Claims Payment Reconsideration
4888 Loop Central Dr. Suite 600

Houston, TX 77081

A network or non-network Provider should file a payment reconsideration within 180 calendar days of the date of the Explanation of Payment (EOP) or, for retroactive medical necessity reviews, as of the date of the denial letter. The request should include an explanation of what is being appealed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include the following:

- Letter stating the reason(s) why the Provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Community Health Choice EOP
- EOP or Explanation of Benefits (EOB) from another carrier
- Evidence of eligibility verification (e.g., a copy of ID card, panel report, call log record with the date and name of the Community person the Provider's staff spoke with when verifying eligibility)
- Medical records
- Approved authorization form from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log, if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was accepted by Community; rejection reports are not accepted as proof of timely filing

When submitting a request for payment reconsideration, we recommend Providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications at least until the request is resolved.

Community will research and determine the current status of a request for payment reconsideration. A determination will be made based on the available documentation submitted with the request and a review of Community systems, policies, and contracts.

The results of the review will be communicated in a written decision to the Provider within 30 calendar days of the receipt of the appeal. An EOP is used to notify Providers of overturned denied claims or additional payments. An upheld denied claim receives a payment reconsideration determination letter. The determination letter includes the following:

- A statement of the Provider's request
- The reviewer's decision, along with a detailed explanation of the contractual and/or medical basis for such decision
- A description of the evidence or documentation that supports the decision
- A description of the method to obtain a second level internal review

If a Provider is dissatisfied with the payment reconsideration resolution, he or she may file a second-level payment reconsideration request. This should be a written request and must be submitted within 30 days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. Once the request is reviewed, the results are communicated in a written decision to the Provider within 30 calendar days of receipt of the request. An EOP is used to notify Providers of overturned denied claims or additional payments. An upheld denied claim receives a payment determination letter. For a decision in which the denial was upheld, the Provider should review the Participating Provider Agreement for any other available methods of dispute resolution. The Provider may also file a complaint with TDI as applicable.

Questions regarding the Community Provider payment dispute process may be directed to Provider Services or a Provider Relations representative.

Provider Complaints and Dispute Resolution Process

Key Terms to Understand

1. **"Adverse Determination"** means a determination by Community or a designee that the healthcare 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 healthcare 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.

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

All professional review actions based on reasons related to professional competence or professional conduct that affects or could affect adversely 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., vision services) may also have additional specifically related processes.

In compliance with state and federal regulations, URAC standards, and Community Health Choice internal standards, Community Health Choice must report to appropriate monitoring agencies, e.g., the Texas 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 Health Choice's Provider network. In the event that Community Health Choice takes an action to terminate, suspend or limit a Provider's participation status with Community Health Choice, Community Health Choice will provide a dispute resolution process as delineated:

Initial Investigation

- The CEO, Medical Director, MCMC, QIC, or NAC:
  Initiates investigation
  Requests and reviews documentation of investigation to determine one of the following actions:
  (1) Suspend Provider
  (2) Terminate Provider
  (3) No action required

B. Results of Investigation

a. The CEO or Medical Director informs the Provider of their suspension or termination and offers the Provider the appeal hearing process.

i. The affected physician is given written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician as well as the numbers and mix of physicians needed by Community. Community allows the physician to appeal the action and provides a written notice of his/her right to a hearing, and the process and timing for requesting a hearing.

ii. Provider has the following options:

- If the Provider does not file an appeal, no further action is needed.
- If the Provider wants to file an appeal hearing, they have to file within 30 calendar days of Community's written notice.The affected Provider must indicate, within the written request, the need for an expedited review, which is scheduled based on the earliest availability of the appeal panel. An expedited appeal will be conducted within ten (10) calendar days of the receipt of the Provider's written request. When the request is received, a panel will be selected and will meet within the ten (10) day timeframe. The Provider is allowed the same process as provided in section C of this policy. Results of the expedited appeal will be communicated to the Provider by phone and in writing within two (2) business days of the final decision.
- The written acknowledgement and notification is provided at least 60 days prior to the date of the hearing. The notice will include a statement that the Provider may either appear in person before the panel on the scheduled hearing date and/or submit a written statement to the panel at least ten (10) calendar days prior to the hearing date.

C. **Provider Appeal Hearing**

1. The Medical Director convenes an appeal panel.

b. Community ensures that the three hearing panel members are peers of the affected physician, with at least one being of the like specialty who is not involved in network management.

c. At the hearing, both Community and the Provider have the right to:

i. Call, examine or cross-examine witnesses;

ii. Be present at the hearing and represented by an attorney, who may present the evidence and argue the case at the hearing, advise his/her client and participate in resolving procedural matters. The practitioner must notify Community that he/she intends to be present in person with the name and address of the attorney, if any at least ten (10) calendar days prior to the date of the hearing

d. Circumstances prompting the consideration of investigation, corrective action or termination are discussed. The requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative.

2. Provider Appeal Panel conducts the review, makes final determination, and advises MCMC of their decision in writing within twenty (20) calendar days.

3. Credentialing staff mails a letter to the Provider with a notification of the outcome within 60 calendar days after the hearing closure.

a) If the panel's review results in reversing the previous action, the Provider is notified, and network participation is re-instated.

b) If the decision is to uphold the previous action, the Provider is mailed a letter inclusive of the appeal panels' findings.

If the decision is to terminate the Provider's credentials, the members receiving care from the Provider shall be notified 30 days prior to the effective date of the termination through the Member Services department. If however, the Provider is terminated due to imminent harm to the member's health or immediately terminated for reasons set forth in the Provider's contract with Community, the members receiving care from this Provider shall be notified immediately.

This policy will be reviewed by the Medical Care Management Committee at least annually and more often if necessary.

Reapplication Subsequent to Adverse Action

A Provider who has had an adverse action taken against him/her may not reapply for network participation for a period of one year (12 months) unless specified otherwise in the terms of the adverse action.

Important Notes

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

- Automatic suspension from the Member panel shall occur whenever:
  - A practitioner's state 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; and
  - A practitioner's medical records are not completed in a timely manner.
- State License Revocation – Whenever a practitioner's license to practice in this state is revoked, his or her panel appointment and practice privileges are immediately and automatically revoked.
- Restriction – Whenever a practitioner's license is partially limited or restricted, his or her practice privileges are similarly limited or restricted.
- Suspension/Probation – Whenever a practitioner's license is suspended or placed on probation, his or her practice privileges are automatically suspended, effective upon, and for at least the term of, the suspension.
- Drug Enforcement – Whenever a practitioner's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a licensing authority (DEA/CDS), his or her privileges to prescribe such substances to MCO enrollees will also be revoked, restricted, suspended, or placed on probation automatically and to the same degree. This will be effective upon, and for at least the term of, the imposed restriction.
- Professional Liability Insurance – A practitioner who fails to maintain a minimum amount of professional liability insurance will have his or her practice privileges immediately suspended.
- Medical Records Preparation and Completion – The Member panel policies, rules and regulations outline the requirements for medical record preparation and completion.
- Timely Completion – A practitioner's failure to prepare and/or complete medical records within the time period stated in the policy may result in the limitation or automatic suspension of some or all of the practitioner's privileges.
- Loss of Hospital Privileges – A practitioner who loses his or her hospital privileges due to incomplete medical records will automatically lose his or her MCO practice privileges for at least the term imposed by the hospital.
- Re-application Subsequent to Corrective Action – A practitioner who has been denied practice privileges or who has been removed from the Member panel during the appointment year may not reapply for panel appointment or practice privileges for a period of one year (12 months), unless specified otherwise in the terms of the corrective action.

Provider Complaint Process

"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 under Section 843.261, 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. The term does not include:

(A) 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
(B) a Provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

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

Community Health Choice
Attn: Service Improvement
4888 Loop Central Dr. Suite 600
Houston, TX 77081
Fax: 713.295.7036
E-mail: ServiceImprovement@CommunityHealthChoice.org

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.

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
Website: https://www.tdi.texas.gov/consumer/health-complaints.html
E-mail: ConsumerProtection@tdi.texas.gov

Provider Appeals - Adverse Determination

As a Provider of Community, you have the right to appeal a Notice of Adverse Determination. An Adverse Determination means that healthcare 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. You will find a one-page Provider Appeal Form on our website at https://provider.communityhealthchoice.org/resources/forms-and-guides/. Please send all written appeals to:

Community Health Choice
Attention: Appeals Coordinator
4888 Loop Central Dr. Suite 600
Houston, TX 77081
Phone: 713.295.6704 or Toll Free:
1.855.315.5386 Fax: 713.295.7033/Attn: Appeals Coordinator

An enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or healthcare 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 Community. 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 healthcare 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 healthcare 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 healthcare Provider who is of the same or similar specialty as the healthcare 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 healthcare Provider's request for specialty review is received. An acknowledgement letter will be sent within five 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 healthcare 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, 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 five 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 to 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 healthcare 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:

- One (1) working day, if your appeal is about emergency or inpatient hospital care; or
- Seventy-two (72) hours, 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 one (1) working day of our decision to provide notification of our determination to process the appeal request as a Standard Appeal. We will also send written communication within three (3) working days informing you that your appeal request will be processed according to the standard appeal timeframe of 30 days.
Send expedited appeals to:

Community Health Choice
Attention: Medical Affairs Appeals
4888 Loop Central Dr. Suite 600
Houston, TX 77081
Fax: 713.295.7033/Attn: Medical Affairs - Appeals

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 timeframes 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.

Mail forms to:

Community Health Choice
Attention: Appeals Department
4888 Loop Central Dr. Suite 600
Houston, TX 77081
713.295.6704
Fax: 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 healthcare 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
Attn: Member Appeals Coordinator
4888 Loop Central Dr. Suite 600
Houston, TX77081
Fax: 713.295.7033/ Attn: Appeals Coordinator
Phone: 713.295.2294 / Toll-free: 1.855.315.5386 / TDD: 7-1-1

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.

Reporting Provider or Recipient Fraud, Waste, or Abuse

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 the 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
Chief Compliance Officer
4888 Loop Central Dr. Suite 600
Houston, TX 77081
Toll-free: 1.877.888.0002

Or go to the Community website at provider.communityhealthchoice.org/resources/waste-abuse-fraud/.

To report Fraud, Waste, or Abuse, 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

Community Health Choice's Special Investigation Unit

Our Special Investigations Unit (SIU) team is responsible for minimizing Community's risk to healthcare fraud. The SIU team partners with Community's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent Providers, and report wrongdoers to the appropriate entity, including but not limited to the Office of Inspector General.

The SIU team also works with state and federal law enforcement and regulatory agencies to detect, prevent, and prosecute health care fraud. The SIU team includes trained professionals with expertise in investigations, audits, health care, nursing, and accounting.

According to the Texas Administrative Code, Title 1, Rule §353.502(g), failure of the provider to supply the records requested by the MCO will result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold.

Additionally, the Code of Federal Regulations, Title 42, Section 424.5(a)(6), provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment."

How to Report Healthcare Fraud to Community's SIU

- Call the Compliance hotline at 1.877.888.0002
- Email us: SIU@CommunityHealthChoice.org
- Write to us:

Community Health Choice Attn:
Special Investigations Unit
4888 Loop Central Dr. Suite 600
Houston, TX 77081