COMMUNITY FIRST
HEALTH PLANS

2021 Provider Manual
Commercial HMO Plan

PROVIDER SERVICES

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COMMUNITY FIRST HEALTH PLANS, INC.

Commercial HMO Provider Manual
2021

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I. INTRODUCTION

Welcome to Community First Health Plans, Inc. (Community First).

The Community First Commercial HMO program at Community First is a managed care plan for commercial HMO employer groups. Our objective is to ensure that members access primary care services appropriately and receive services in the most cost-effective setting. Our network comprises physicians, allied and ancillary health care providers, hospitals and other facilities selected to provide quality health care to our members. The Primary Care Provider (PCP) is responsible for managing the overall medical care of patients and coordinating referrals to specialists and inpatient/outpatient facilities. A PCP is a Community First provider with one of the following specialties: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, or Pediatrics.

This manual is to assist you and your staff in working with us to deliver quality health care to Community First members. It provides information regarding our utilization and quality management programs, preauthorization and referral notification procedures, filing of claims, and our appeals process. We encourage you and your staff to review this manual carefully and contact your Network Management Representative if you have any questions, comments or concerns. We welcome provider suggestions for enhancing this manual and will be conducting semiannual provider surveys asking for your comments on the efficiency of training, communications programs, and any ideas for improvements.

We will mail bulletins to your office to advise you of any changes/updates to this manual. In addition, Community First will publish and distribute a tri-annual newsletter to all providers. The newsletter will include information about Community First services, policies and procedures, and appropriate government statutes and regulations.

A. The Role of the Primary Care Provider

Our PCPs play an integral role in helping us meet the objectives of our health plan. Community First places its main focus on the total wellbeing of the member while providing a "medical home" where the member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. Members also are encouraged to become more involved in their own health care and maintenance of their own wellness. The PCP is responsible for teaching members how to use available health services appropriately.

The PCP will provide preventive health services in accordance with the health plan standards and related medical policies. They also will coordinate the provision of all covered services to members; initiate referrals to network specialty care providers, network facilities and contractors; monitor the member's progress; facilitate the member's return to the PCP when medically appropriate; and educate members and their families regarding their medical care needs. It is the responsibility of the PCP to contact Community First to verify member eligibility and/or to obtain authorizations for covered services.

The PCP will provide or arrange for the provision of covered services and/or telephone consultations during normal office hours, as well as on an emergency basis, 24 hours a day, seven days a week. The PCP should educate members to seek his/her services before accessing any other health services, except in emergency situations.

PCPs must assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral.

The PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

PCPs must provide preventative care:

1. To children under age 21 in accordance with AAP recommendations.

2. To adults in accordance with the U.S. Preventative Task Force requirements.

A member who appears on a PCP's monthly member roster is considered to be an existing member from the first month that he/she appears on the roster and therefore cannot be refused services while assigned to that PCP.

B. The Role of the Specialty Care Provider

The specialty care provider is responsible for providing medically necessary services to Community First members who have been referred by their PCP for specified treatment or diagnoses. Specialists should verify the eligibility of the referred member prior to rendering services. If additional visits or services are necessary, the specialist may provide or arrange for services through Community First's Health Services Management Department. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP's and specialist's medical records.

C. Providers for Members with Disabilities and/or Chronic/Complex Conditions

On an individual basis, Community First may allow a specialist currently treating a member with disabilities or chronic/complex conditions to serve in the capacity of PCP. The network specialist must agree to perform all PCP duties, care coordination, and such duties must be within the scope of the participating specialist's certification. Network specialists wishing to become a PCP for members with disabilities or chronic/complex conditions should complete the **Request for Continuity of Care** form **(Exhibit 1)** and submit the form to Community First's Health Services Management Department for review and approval by Community First's Medical Director.

The Medical Director will review the medical appropriateness information. If Continuity of Care Coverage is appropriate, the Medical Director will instruct Network Management to obtain the written agreement from the specialist that he or she is willing to accept responsibility for coordination of all of the Member's health care needs. If the specialist is not willing to serve as the PCP, the request cannot be approved under the Continuity of Care policy.

Community First will approve or deny the request for Continuity of Care and provide written notification of the decision to the member no later than 30 days after receiving the request. If the request is denied, Community First will outline, via the written notification to the member, the reasons for the denial of the request and the mechanisms to initiate an appeal. To obtain further assistance in this process, please contact the Health Services Management Department at **(210) 358-6050**.

Community First requires all non-Primary Care Physicians who wish to be a Member's PCP to initiate a written request for certification as a PCP and to complete an amendment to their existing Professional Provider Agreement that outlines their duties and responsibilities. The written request must contain the following information:

1. Certification by the non-primary care physician specialist as a PCP.
2. A signed statement by the non-primary care physician specialist that he or she is willing to accept responsibility for the coordination of all the member's health care needs including referrals to other specialists.
3. The signature of the member concurring with the request.

D. Limited Provider Networks

A member may select a PCP who is part of a Limited Provider Network (an association of health professionals who work together to provide a full range of health care services). If a member selects a PCP in a Limited Provider Network, the PCP will arrange for services through a specific group of specialists, hospitals and/or ancillary providers who are part of the PCP's network. In such a case, a member may not be allowed to receive a service from any physician or health care professional that is not part of the PCP's network, (excluding OB/GYN and behavioral health providers) except in the case of an emergency as defined in this Provider Manual (Section IV, Utilization Management, Subsection E).

Providers in a limited provider network that uses an Independent Practice Association (IPA) for claims processing should submit their claims to that IPA, not to Community First. IPA claims that are filed to Community First will be denied.

E. Provider Office Relocations

If a provider relocates offices or expands to additional offices, the provider should notify Community First within ten (10) days and should not render services to

members until Community First has approved the new office locations.

II. LEGAL AND REGULATORY

Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Provider Agreement and Community First's contract with the Texas Department of Insurance, the Community First HMO Program, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state of federal law relating to the delivery of services pursuant to the Provider Agreement, or any violation of Community First's contract with the Texas Department of Insurance could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

A. Law, Rules and Regulations

Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Provider contract:

1. Environmental protection laws:

   a. Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq*.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;

   b. National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq*.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;

   c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");

   d. State Clean Air Implementation Plan (42 U.S.C. §740 *et seq*.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and

   e. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;

2. State and federal anti-discrimination laws:

   a. Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);

b. Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);

c. Americans with Disabilities Act of 1990 (Public Law 101-336); and

d. Title 40, Texas Administrative Code, Chapter 73;

3. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq*.) and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.)* regarding employment verification and retention of verification forms; and

4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).

B. Liability

1. In the event Community First becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against the Community First will be through Community First's bankruptcy, conservatorship, or receivership estate.

2. The Provider understands and agrees that Community First's Members may not be held liable for Community First's debts in the event of the entity's insolvency.

C. Marketing

Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with informing Members which Plans a provider participates with or to contract with additional health plans.

D. Medical Consent Requirements

Providers must comply with medical consent requirements in Texas Family Code §266.004, which require the members medical consent to consent for the provision of medical care.

Providers must notify the medical consenter about the provision of emergency services no later than the 2nd business day after providing emergency services, as required by Texas Family Code §266.009.

E. Member Communications

Community First is prohibited from imposing restrictions upon the Provider's free communication with a Member about the Member's medical conditions, treatment options, Community First referral policies, and other Community First Health Plans policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

F. Provider Responsibilities

At the request of Community First, Providers must testify in court as needed for child protection litigation.

G. Professional Conduct

While performing the services described in the Provider contract, the Provider agrees to:

1. Comply with applicable state laws, rules, and regulations and Community First's requests regarding personal and professional conduct generally applicable to the service locations; and

2. Otherwise conduct themselves in a businesslike and professional manner.

H. Contract Termination

Community First must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a provider, including an STP. At least 30 days before the effective date of the proposed termination of the provider's contract, Community First must provide a written explanation to the provider of the reasons for termination. Community First may immediately terminate a provider contract if the provider presents imminent harm to patient health, actions against a license or practice, fraud or malfeasance.

Within 60 days of the termination notice date, a provider may request a review of Community First's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license, fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Community First. The decision of the advisory review panel must be considered by Community First but is not binding on Community First. Community First must provide to the affected provider, on request, a copy of the recommendation of the advisory review panel and Community First's determination.

I. Gifts or Gratuities

Provider may not offer or give anything of value to an employee of Community First Health Plans in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the Provider contract at any time for violation of this requirement.

J. Third Party Recovery

Provider understands and agrees that it may not interfere with or place any liens upon the state's right or Community First' right, acting as the state's agent, to recovery from third party resources.

K. Tuberculosis (TB)

Providers must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). Providers must report to the Texas Department of State Health Services (DSHS) or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat.

L. Women, Infants and Children (WIC)

Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.

III. HOW TO CONTACT US

Listed below are important telephone numbers for you to use when you need to reach us:

From Outside Bexar County **(800) 434-2347**

Health Services Management **(210) 358-6050**
Preauthorization/Referral Notification Fax (210) 358-6040

Urgent Care
Please contact Community First **(210) 227-2347**
After Hours you will be transferred to Nurse Advice Line

Behavioral Health Authorization/Case Management **(210) 358-6100**
(800) 434-2347

Member Services Eligibility/Benefits Verification Interpreter Services - Sign and language	**(210) 358-6070**
TDD (for the hearing impaired)	**(210) 358-6080** **(800) 390-1175**
Network Management	**(210) 358-6030**
Claims Information	**(210) 358-6200**

Community First has contracted with an interpreter service for any provider office that does not have bilingual employees or sign language interpreters. Services are available for sign language, Spanish, English, and other languages that members may speak, such as Vietnamese. The service is accessible 24 hours a day, seven days a week. Providers can use the service during normal business hours by calling our Member Services Department at **(210) 358-6070**, and after hours by calling (**210) 358-6070** and being automatically transferred to Nurse Advice Line.

You may also visit the Community First website at www.CommunityFirstHealthPlans.com. At the "Physicians" link you will find pertinent information and downloadable documents such as the preferred drug lists and authorization/referral forms.

IV. MEMBER INFORMATION

A. Verifying Eligibility and Benefits

Each Community First HMO member is issued an identification card and is instructed to present the plan ID card when requesting medical services. The ID card indicates pertinent member information, PCP name and telephone number, co-payment amounts, and Community First telephone numbers.

When new members are enrolled into the plan, they are given the opportunity to choose a PCP from among those accepting new patients. If a member fails to choose a PCP at the time of enrollment, Community First will assign a PCP to the member.

At the time of the visit, ask the member to show the plan ID card, or in some instances, the Community First enrollment form. New members may present a copy of their enrollment form as proof of coverage during the first thirty (30) days of their enrollment in the plan. The Community First ID card or enrollment form, however, does not guarantee eligibility for coverage. Whether a member presents a card or an enrollment form, providers are encouraged to verify eligibility by calling the Community First Member Services Department. Verifying eligibility before rendering services is very important.

PCPs should first verify a member's eligibility by consulting the Community First Monthly Member Roster. If the member's name is not on the roster, please call Community First, Member Services Department.

Members are encouraged to select their own PCPs. If a member does not select a PCP during his/her initial enrollment, Community First will assign a PCP to the member.

If a member has selected a PCP who is part of a Limited Provider Network you may not see that member unless you have written authorization from the Limited Provider Network. Any services except emergency services will not be reimbursable.

Listed below are helpful ways to verify eligibility:

1. Plan eligibility line at **(210) 358-6070** (outside Bexar County **800-434-2347**)
2. Verify online via Community First's Internet Portal
3. Monthly Member eligibility report (PCP only)

If a member has questions about benefit coverage or wants to change his or her PCP, please ask the member to call our Member Services Department at **(210) 358-6070**.

B. Copayments, Deductibles & Coinsurance

Provider is responsible for collecting at the time of service any applicable copayments, deductibles or coinsurance in accordance with the member's certificate of coverage.

C. Span of Eligibility

Community First will arrange for all covered services for the period members are eligible with Community First, except as follows:

- *Inpatient admissions prior to enrollment with Community First:* Community First is responsible for physician and non-hospital services from the date of enrollment with Community First, provided Community First is notified of the admission by the Member or the Member's provider. Community First is not responsible for any hospital charges for members admitted prior to enrollment with Community First.
- *Inpatient admissions after enrollment with Community First:* Community First is responsible for authorized, covered services until the hospital discharges the member, unless the member loses eligibility.
- *Newborns:* Community First is responsible for all covered services related to the care of a newborn child from the date of birth if the mother is enrolled with Community First at the time of birth. Coverage for the child will terminate on the 32nd day if the child is not enrolled in the health plan before the end of that period. Parents of newborns must notify their employer's benefit representative within 31 days of the birth.

- *Hospital Transfers:* Discharge from one hospital and readmission to the same hospital or admission to another hospital within 24 hours for continued treatment should not be considered as discharged under this section.

- *Psychiatric Care:* Inpatient psychiatric care, in a freestanding psychiatric facility for members, is Community First's responsibility from the member's date of enrollment with Community First.

Note: Community First's responsibilities shown above are subject to contractual requirements between Community First and provider (i.e., referral, claims submission and pre-authorization requirements).

D. Disenrollment

Community First members may automatically be disenrolled from Community First due to nonpayment of premiums. In the event the individual regains their eligibility within 90 days or less, they will be re-enrolled as members with the same PCP.

Community First has the right to request disenrollment of members from our health plan. The member may request the right to appeal such decision. The PCP will be responsible for directing the member's care until the disenrollment is made. A request to disenroll a Community First member ***is acceptable*** under the following circumstances:

- Member misuses or lends his/her Community First membership ID card to another person to obtain services.

- The member is disruptive, unruly, threatening or uncooperative to the extent that the member seriously impairs Community First's or a provider's ability to provide services to the member. This occurs however, only if the member's behavior is not due to a physical or behavioral health condition.

- The member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First to arrange for the treatment of an underlying medical condition.

E. PCP Request for Member Transfer

The PCP must submit a request to Community First in writing to transfer a Community First member from the PCP's practice and follow Community First's **Provider Request for Transfer Form** policy and procedure **(Exhibit 2)**. If you have any questions regarding this process, please contact Community First's Network Management Department at **(210) 358-6030**.

F. Member PCP Change

A member may call Community First to request a change in PCP. If a member requests a PCP change before the 15th day of the month, the change usually becomes effective on the first day of the following month. Changes received after the 15th day of the month will become effective the first day of the second month following the change request.

G. Pre-existing Conditions

The provider is responsible for arranging for the provision of all covered services to each eligible Community First member beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. All arrangements for covered services will be in accordance with contractual requirements between Community First and the provider and with all applicable laws, rules and regulations.

H. Continuity of Care

Community First provides members with a process to address continuity of care issues involving continuation/transition of ongoing care and to request the use of a specialist as their PCP. This policy outlines the situations and describes the process for requesting this type of coverage.

Continuity of Care coverage can be approved for two different circumstances:

- Transition of Care
- Specialty Care Provider (SCP) as PCP

Transition of care involves any active course of treatment rendered by a non-participating specialist that is expected to continue for 60 days following the members' effective date with Community First. An "active course of treatment" is one in which discontinuity would cause a recurrence or worsening of the conditions under treatment and interfere with anticipated outcomes (examples would be: post-surgical care, illness recovery, psychotherapy for an acute exacerbation, or chronic psychiatric condition).

Specialist as PCP coverage is designed to provide for the complex care needs associated with members who have either disabilities or chronic/complex medical or behavioral conditions. Through collaboration with Community First nurse case managers, members with disabilities or chronic/complex medical or behavioral conditions are encouraged to maintain a stable "medical home" (PCP), with unduplicated services through the appropriate development of a care plan. In certain qualifying situations, Community First may allow a participating specialist currently

treating a member with disabilities or chronic/complex conditions to serve in the capacity of the PCP, using the criteria set forth in Section I.C of this Manual. PCPs and specialists can call our Health Services Management Department at **(210) 358-6050** to address any continuity of care issues or can fax the **Request for Continuity of Care** form **(Exhibit 1)** to (**210) 358-6040**.

I. Release of Information

You should obtain from Community First members a signed authorization for release of information. You may use the standard CMS-1500 1500/UB04 or develop your own form. If you develop your own form, the release should allow you to disclose information to Community First. This will enable us to process claims and perform our utilization management and quality management functions.

J. Member Privacy

As of April 14, 2003, both Community First and all providers in the Community First network will be required to comply with federal regulations adopted under the Health Insurance Portability and Availability Act of 1997 governing the privacy of individually identifiable health information. Through Senate Bill 11 passed during the 77th Legislative Session, Texas also substantially incorporated HIPAA privacy regulations into Texas law, giving the state its own enforcement powers. Community First is enacting policies and processes to meet the compliance deadline and anticipates that the providers in its network are also taking steps to ensure compliance.

Provider must treat all information that is obtained through the performance of the services included in the Professional Provider Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations.

Provider shall not use information obtained through the performance of the Professional Provider Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Agreement.

K. Protected Health Information (PHI)

Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Provider must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

L. PCP Request to Change Panel Status

To change your Community First panel status, please notify Community First's Network Management Department in writing (via mail or fax) of your request to

either open or close your panel. *According to your agreement with Community First, you must notify Community First in writing at least 60 days prior to any action by you to limit or close your panel to Community First HMO members. Notifications less than 60 days to limit or close your panel will be considered on a case-by-case basis*.

A member who appears on a PCP's monthly member roster is considered to be an existing member from the **first** month that s/he appears on the roster and therefore cannot be refused services while assigned to that PCP.

M. Interpreter Services

Community First has linguistic and interpreter services available for its members to ensure effective communication regarding treatment, medical history or health education. These interpreter services are available on an "on-call" basis. Our contracted interpreter services provide Community First members access to professionals trained to help with technical, medical or treatment information when a family member or friend interpreter is inappropriate. To arrange for a sign interpreter or language interpreter for a Community First member, please contact Community First's Member Services Department at (**210) 358-6070**.

N. Member Rights and Responsibilities

Listed below are the "Rights and Responsibilities" for Community First members that are printed in the Community First Member Handbook.

As a member you have the right to:

- Understand how to access Community First's health care delivery system;
- Receive a list of participating PCPs;
- Select one of Community First's PCPs within 30 calendar days of
- enrollment;
- Receive prompt, courteous, and appropriate medical treatment;
- Access care without physical or communication barriers;
- Understand your health problems, the recommended treatment and the reason for the recommendation, alternatives available for treatment and the risks involved, and how to care for yourself to maintain optimum health;
- Consent to all treatments unless a life-or-limb threatening emergency exists;

- Participate in decision-making about your health care and treatment plan, accept or refuse medical, surgical, or behavioral health treatments to include establishing advanced directives as permitted under federal and state laws;

- Request a second opinion through Community First;

- Have someone not directly involved in your care be present during your examination or treatment;

- Take part in available wellness programs;

- Review your medical records, have your medical care and medical records treated with privacy and confidentiality in accordance with the law and professional medical ethics;

- Suggest how we can improve our services to you and other members;

- Be treated courteously and in a manner that respects your right to privacy and dignity in a non-discriminatory manner;

- Contact Community First Member Services to file an oral or written complaint or appeal;

- Appeal a decision of Community First related to the resolution of a concern, in accordance with Community First's procedures, and in a timely manner;

- Have these rights and responsibilities explained to you by Community First's Member Services Department.

As a member, you have the responsibility to:

- Take responsibility for personal habits that affect your health;

- Learn how Community First works and appropriately use the health plan;

- Schedule appointments for routine care; keep scheduled appointments and arrive on time;

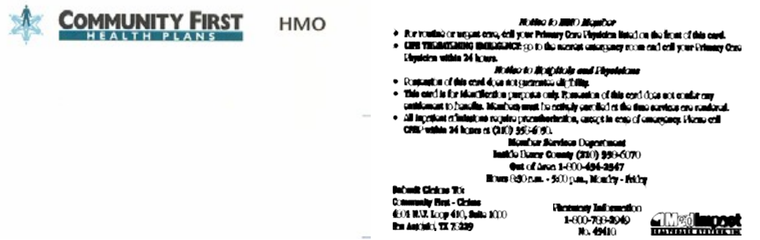
- Promptly contact your provider when you are unable to keep an appointment;

- Understand when you should or should not go to the emergency room;

- Always contact your PCP for your non-emergency medical needs;
- Establish a continuous and satisfactory relationship with your PCP;
- Communicate to your PCP any concerns that you or your family members may have about your health or health care;
- Give your provider complete and accurate information and help providers obtain your medical records;
- Cooperate with the treatment instructions you and your health care provider agree upon;
- Follow Community First's procedures for obtaining care after normal business hours;
- Use only Community First PCPs or participating specialists (obtaining approval from your PCP when applicable) and medical facilities, for urgently needed medical care, except in the case of emergencies or, while away from the service area, or if medically necessary services are not available within Community First's network;
- Advise Community First as soon as possible whenever you receive care from a provider outside Community First's network, whether inside or outside the service area;
- Carry your Community First member ID card with you at all times while enrolled;
- Pay all applicable co-payments at the time services are rendered;
- Pay for services or supplies not covered by Community First;
- Contact Community First if there are any changes in family status, address, phone number, employment status, and other insurance coverage;
- Respect the dignity of other members and Community First staff and providers.

O. Identifying Members

Below is a sample copy of a Community First identification card:



P. Billing Members

By entering into an Agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services you render to members. ***This means that you may not bill members for the difference between your normal charge and the contracted rate with Community First for rendering covered services.***

You have also agreed that in no event, including, but not limited to nonpayment by Community First or our insolvency or breach of our agreement with you, will you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member, Employer group, or any persons other than Community First for services provided pursuant to your agreement with Community First.

In addition, you may not bill a member if any of the following circumstances occur:

- Failure to submit a claim, including claims not received by Community First.
- Failure to submit a claim to Community First for initial processing within the ninety-five (95) day filing deadline.
- Failure to submit a corrected claim within the sixty (60) day filing re-submission period.
- Failure to appeal a claim within the sixty (60) day appeal period.

Q. Member Acknowledgment Statement

You may not bill a member for covered services, which we determine are not medically necessary, unless you obtain the member's prior, written, informed consent. The member's consent will not be considered informed, unless you explain to the member before you render the services that Community First will not pay for the services, and that the member will be financially responsible.

A provider may bill the member for a service if both of the following conditions are met:

- The patient requests the specific service.
- The provider obtains a written acknowledgement statement signed by the patient and the provider.

R. Family Planning

If a member requests contraceptive services or Family Planning services providers must also provide the member with counseling and education about Family Planning and available Family Planning services.

Providers cannot require parental consent for members who are minors to receive Family Planning services.

Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on Family Planning services to members.

S. Advance Directives

Provider must comply with the requirements of state and federal laws, rules and regulations related to advance directives.

T. Audit or Investigation

Provider agrees to provide the following entities or their designees with prompt, reasonable access to provider's contract and any records, books, documents and papers that are related to the provider's contract and or Provider's performance of its responsibilities under contract:

1. Community First;
2. U.S. Department of Health and Human Services;
3. Office of Inspector General;
4. An independent verification and validation contractor or quality assurance contractor;
5. State or federal law enforcement agency;
6. Special or general investigation committee of the Texas Legislature;
7. The U.S. Comptroller General;

8. The office of the State Auditor of Texas; and

9. Any other state or federal entity identified by Community First.

Provider must provide access wherever it maintains such records, books, documents and papers. Provider must provide such access in reasonable comforts and provide any furnishings, equipment and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access made before, but are not limited to, the following purposes:

1. Examination;

2. Audit;

3. Investigation;

4. Contract administration;

5. The making of copies, excerpts or transcripts; or

6. Any other purpose Community First deems necessary for contract enforcement or to perform its regulatory functions.

V. UTILIZATION MANAGEMENT

A. Overview

Community First's utilization management program determines whether proposed or rendered medical services and/or supplies are medically necessary and appropriate, are of a generally acceptable high quality and appropriate frequency, done in the appropriate setting, and covered in the member's benefit plan. Program components include referral notification/preauthorization, concurrent stay review, level of care review, discharge planning, retrospective review, disease management, and case management.

Note: These determinations only affect payment for services by Community First. The decision to provide treatment is between the member and the attending physician.

Besides processing requests for authorizations and referral notifications, utilization management analyzes utilization patterns, and provides an appeal process to address disputes in a timely manner (Refer to the Appeals, Section IX of this manual).
All reimbursement is subject to eligibility and contractual provisions and limitations. Successful operation of our utilization management program depends upon your cooperation by:

- Accepting and returning our phone calls concerning our members;
- Allowing us to review medical and financial records concerning care rendered to our members;
- Participating with us in discharge planning, disease management, and case management; and
- Participating in our Quality Improvement Committee proceedings when necessary.

B. Preauthorization

The PCP is responsible for initiating all referrals to specialty care providers (see Section C - Referrals). However, Community First requires preauthorization for the services outlined in the **Authorization List (Exhibit 3)**. This authorization list is subject to change. Community First will provide at least 60 days' notice of changes in the authorization list.

Note: Community First must give preauthorization before the patient's admission to a facility or visit to a specialty care provider for any service indicated in the authorization list. Preauthorizations are valid for thirty (30) days from the date issued, unless a longer time frame is prearranged. Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If preauthorization expires, call Community First. All services listed on the **Authorization List (Exhibit 3)** will be subject to medical necessity review in advance of the services being rendered. Failure to obtain preauthorization in advance of the service being rendered will result in an administrative denial of the claim, and providers cannot bill Members for covered services.

PCPs and Specialists can call our Health Services Management Department at **(210) 358-6050** to obtain preauthorization or fax the completed **Texas Referral/Authorization form (Exhibit 4)** to **(210) 358-6040**. The Health Services Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. CST. After hours and on weekends or holidays we will accept either your fax or phone message as meeting notification requirements, however, the services listed on the preauthorization list will need to be preauthorized by calling Community First to obtain an authorization number.

Please have the following information available when requesting preauthorization:

- Member's name and ID Number
- Primary diagnosis with ICD-9 Code, if known
- Surgery/Procedure with CPT Code, or purpose and number of visits

- Anticipated date of service or admission date
- Name of consultant/facility
- Expected length of stay (inpatient only)

Our Health Services Management Department will issue an authorization number for approved requests. Faxed requests will be faxed back to the requesting provider including the authorization number. Telephone requests will receive an authorization telephonically.

If we pend a request because information is incomplete, the provider will be contacted. Once we receive the required information, we will either approve the request or send the information to the Community First Medical Director for final review. If we do not receive the required information, the services will be denied for lack of requested information.

We will deny requests that do not meet eligibility and/or benefit criteria, and notify the provider by phone and letter, either by fax or mail, within 48 hours.

C. Referrals

The PCP or specialist may directly refer a member for services that do not require preauthorization. All referrals must be to a Community First network provider. Community First's provider network may occasionally change. Contact the Network Management Department at **(210) 358-6030** for current provider information. Use of a non-participating provider requires preauthorization by Community First. Specialists must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Community First requires preauthorization for court mandated inpatient psychiatric care for all Members regardless of age.

Note: Payment for services requiring notification or preauthorization is contingent upon verification of current eligibility and applicable contract specifications at the time of service. For verification of eligibility call (210) 358-6070.

D. Self-Referrals

Members may self-refer for the following services:

- Emergency Care
- Obstetrical and/or Gynecological Services
- Routine Vision for in plan vision Providers Only (call Member Services to verify benefits and in plan providers)

- Behavioral Health – first 20 outpatient visits to a participating provider

The PCP is encouraged to provide or coordinate referrals for the services shown above.

E. Emergency Care

Emergency Care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in:

- Placing the Member's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction to any bodily organ or part;
- Serious disfigurement;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Community First covers services for a medical emergency anywhere in the world, 24 hours a day. If a medical emergency occurs, whether in or out of Community First's service area, Members are instructed to seek care at the nearest hospital emergency room or comparable facility. The necessary emergency care services will be provided to covered Members, including transportation, treatment and stabilization of an emergency medical condition, and any medical screening examination or other evaluation required by state or federal law, which is necessary to determine if a medical emergency exists.

When the condition of the Member requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance is an emergency service. If a Member needs to be transferred to another facility and the medical condition of the Member requires immediate medical attention, the transfer may be considered as an emergency transfer.

Community First should be notified of emergency admissions, transportations or procedures within 24 hours, or the next business day.

If it is determined that a medical emergency does not exist (emergency care is not rendered), the Member must contact his or her PCP to arrange any non-emergency care needed. If the Member chooses to use the emergency room or other similar

setting for care that does not meet the definition of emergency care, the member will be responsible for all billed charges.

If the Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the Member may be transferred to a network hospital as soon as the attending provider deems it medically appropriate. Once the patient/member is stabilized, the treating provider is required to contact Community First to obtain authorization for any necessary post-stabilization services. Community First will process all requests for authorization of post-stabilization services within one (1) hour of receiving all necessary information.

F. Urgent Care

An ***urgent condition*** means a health condition, including an urgent behavioral health situation, which 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 PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

For after-hours urgent care, and certain instances during normal office hours, Community First has arrangements with Urgent Care Clinics listed in the Provider Directory. In addition, we have arrangements with **Nurse Advice Line,** a **24-hour** nurse triage service staffed by registered nurses who provide advice according to written protocols and assist Members in accessing treatment.

Services provided at the Urgent Care Clinics are limited to:

- **After Hours Urgent Care**

Weekdays	Monday-Friday	5:00 p.m. - 8:30 a.m.
Weekends	Friday-Monday	5:00 p.m. - 8:30 a.m.
Holidays	Preceding Day-Following Day	Day Prior 5:00 p.m.- Day after 8:30 a.m.

- **During Normal Office Hours**

You may refer a patient to an Urgent Care Clinic during normal office hours only if the PCP is unavailable, and a triage nurse has determined that the patient requires urgent care, ***not hospital emergency*** care. The PCP's nursing staff should triage the patient or refer to the Nurse Advice Line if the PCP's nursing staff is unavailable.

Referrals to the Urgent Care Clinic: When referring a Member to an Urgent Care Clinic, the PCP or PCP's nursing staff should call the clinic and notify the clinic that they are referring the patient to. If a Member goes to one of the clinics without approval, the clinic must contact the PCP. If the PCP does not respond within a reasonable length of time, depending on the medical situation, the clinic should call Community First Health Services Management Department, or the Nurse Advice Line for approval.

G. Behavioral Health Services

Introduction

Community First is committed to ensuring Members have access to quality behavioral health services that are clinically appropriate and in the most cost-effective setting. Our Behavioral Health network is comprised of psychiatrists, psychologists, social workers, licensed professional counselors, licensed chemical dependency counselors, other licensed mental health professionals, and freestanding psychiatric hospitals and psychiatric units in medical hospitals.

It is critical to the integration of the Members overall health care that the Behavioral Health provider and the Member's PCP communicate regarding relevant medical information. This interaction should be with the consent of the Member and documented in the Member's medical records.

Community First's Case Management staff are available to assist you in identifying and accessing network Behavioral Health providers on behalf of your patients. We encourage you to call our Health Services Management Department, **(210) 358-6050**, with any questions regarding Behavioral Health Services.

Definitions

Behavioral Health Services means covered services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention without which a Member would present an immediate danger to themselves or others or which renders the Member incapable of controlling, knowing or understanding the consequences of their actions.

Screening and Assessment

When assessing Members for behavioral health services, providers must use the DSM-IV multi-axial classification and report axes I, II, III, IV, and V. Community First may require use of other assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the Member's medical record.

All network PCPs must ensure all Members receive a screening, evaluation, and referral and/or treatment for any identified behavioral health problems and disorders.

Behavioral Health Services

Depending on the member's benefit plan, behavioral health services may include the following:

Outpatient Services: individual, family, group counseling/therapy, medication management provided by a network behavioral health practitioner.

Inpatient/Acute Care: a highly structured 24-hour program in which the member's care is directed by a psychiatrist.

Partial Hospitalization Program (PHP): a highly structured program used as an alternative to acute inpatient admission, usually a day program that may include educational services.

Intensive Outpatient Treatment/Day Treatment (IOP): a highly structured program used as a prevention, alternative or transition from acute inpatient hospitalization and/or partial hospitalization; can be a day, evening, or weekend program.

Off-site Services: services provided to help reduce or avoid inpatient admissions (i.e., home-based services, school-based services, and mobile crisis services).

Residential Services: a 24-hour-a-day program that is not inpatient hospitalization (i.e., crisis stabilization, short-term respite, residential treatment, respite residential, group homes).

Other Services: Other services may be available if medically indicated.

The behavioral health provider must verify the benefits for which the member is eligible. Please call Member Services at (210) 358-6070. Benefits differ among employer groups. It is critical that verification of eligibility and benefits be performed and re-verified during treatment.

Measurement Instrument

Behavioral Health providers must evaluate member's progress using the **Behavioral Health Notification Form (Exhibit 5)** at intake, quarterly at minimum, and at termination of the treatment plan, or as significant changes are made in the treatment plan.

Documentation Requirement

Providers must document the following for Community First:

1. Primary and secondary (if present) diagnosis;
2. Assessment information, including results of a mental status exam;
3. Brief narrative summary of each clinical session;
4. Scores on each outcome rating form(s);
5. Referrals to other providers or community resources;
6. Treatment plans;
7. All other relevant care information.

Member Assessment and Referral

A Member can access behavioral health services by:

- Self-referral to any network behavioral health provider;
- Calling Community First at **(210) 358-6100** or **800-434-2347** and obtaining the names of network behavioral health providers

Community First does not require that Members have a PCP referral to obtain an initial consultation visit with a network behavioral health provider. Outpatient behavioral health services beyond the first 20 visits, unless an emergency, must be preauthorized by sending the **Request for Additional Authorized Services (Exhibit 6)** and treatment plan to Community First's Health Services Management Department fax **(210) 358-6040**. Requests must be received no later than 7 days after the 20th visit. Case Managers are available to receive calls 7 days a week, 24 hours a day, including holidays.

Timely and appropriate Member assessment and referrals are essential components of Community First's managed care program. The clinical intake staff will conduct an initial telephone assessment to evaluate risk and determine the need for a referral to a network behavioral health provider for a face-to-face clinical assessment and/or treatment. Referrals are based on matching the Member's needs with the provider's geographic availability and specialization.

A psychiatric consultation is required for the following:

- The Member has a history of hospitalization(s);
- The Member is taking a neuroleptic medication;
- The Member's medical condition may be contributing to present psychiatric symptoms; and/or
- The assessment of the diagnosis of ADD/ADHD

Consultation regarding the appropriateness of the level of care is available through Community First's Case Management staff. Psychological/Neurological testing requires preauthorization by faxing the **Psychological Testing request Form (Exhibit 7)** to **(210) 358-6040**.

Summary Reports to Primary Care Providers

The Behavioral Health provider shall function as a member of the PCP team by coordinating with the PCP and Community First as appropriate. All providers rendering behavioral health services to Members must send completed **Behavioral Health Report to Primary Care Physician (Exhibit 8)** to the PCP upon beginning behavioral health services and every three months that the Member remains in treatment and/or upon discharge. A copy of the report will be placed in the Member's permanent record.

Consent for Disclosure of Information

A written medical record release must be obtained from the Member, or a parent or legal guardian of the Member, before the provider can send the Member's Behavioral Health Report to the PCP. The Member will be advised that he/she is not required to sign the release and treatment will not be denied if the Member objects to signing the form. The provider will place a copy of the signed release in the Member's record.

Litigation

Behavioral Health Providers agree to testify in court as needed for child protection litigation.

Discharge Planning and Aftercare

Providers must notify a Community First Case Manager when they discharge a Member from an inpatient, residential treatment, partial hospitalization, or intensive outpatient setting. Members should have a copy of the discharge plan, which includes an aftercare appointment or entry into a lesser level of care.

Community First requires all Members discharged from an inpatient setting to have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to follow through with aftercare appointments and placement.

Rescheduling Appointments

Community First requires that all providers contact Members if the member misses a scheduled appointment and reschedule such appointment within 24 hours of the missed appointment.

Quality Management Improvement Program/Behavioral Health Medical Records

Our Quality Management and Improvement Program is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the healthcare delivery system. Components of this program include problem-focused studies, peer review, risk management, medical record review, ongoing monitoring of key indicators, and behavioral healthcare services evaluation.

The success of the QMIP depends upon your cooperation by:

1. Providing us with medical records concerning our Members upon request;

2. Maintaining the confidentiality of Member information;

3. Promptly responding to our phone calls or letters concerning Quality Management issues;

4. Cooperating with our Quality Improvement Committee proceedings;

5. Participating on our Quality Improvement Committee, Credentials Committee, Utilization Management or Pharmacy and Therapeutics Committee, if appropriate. These committees consist of network providers who are board certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Network Management Representative.

Utilization Management

Successful operation of our Utilization Management program for behavioral health depends upon your cooperation by:

1. Accepting and returning our phone calls concerning our Members;

2. Allowing us to review medical and financial records concerning care rendered to our Members;

3. Participating with us in discharge planning, disease management, and case management;

4. Participating with our Community First committee proceedings when appropriate.

Emergency and Urgent Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention/medical attention. In an emergency and without immediate intervention/medical attention, the Member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing, or understanding the consequences of his or her actions.

Emergency behavioral health conditions include Emergency Detentions as defined under Tex. Health & Safety Code § 573.0001-573.026 and under Tex. Health & Safety Code § 462.001-462.081.

In the event of a behavioral health emergency, the safety of the Member and others is paramount. The Member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 9-1-1 should be contacted if the Member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the Member is any of the following:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug-dependent, with signs of severe withdrawal

Community First does not require precertification or notification of emergency services, including emergency room and ambulance services. If the Member cannot STAR Kids Provider Manual | Community First Health Plans 94 be seen within six hours of initial contact, then the Member should be referred to the ED.

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the Member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

VI. CASE MANAGEMENT SERVICES

Community First is committed to providing the most appropriate and efficient level of service to our customers. Community First believes that case management is the cornerstone of managed care and is an essential component of Utilization Management. Through effective case management communication is improved, thereby assuring that services are delivered at the appropriate level of care, maximizing use of all resources. Community First's Case Management Program emphasizes the importance of communication between PCPs, specialists, and Community First.

Community First's Case Management Program, or its designee, provides case management services to Community First Members. When a Member is identified or referred to Community First's Case Management staff, a needs assessment is conducted. Suggested criteria for referrals to the Case Management Program may include any combination of the following:

- Frequent acute care admissions, more than two in six months;
- Extended length of stay, more than seven days;
- Non-compliance with medical regimen;
- Knowledge deficit related to health care;
- Multiple active chronic diseases;
- Frequent emergency room visits, more than two in six months;
- Ineffective coping;
- Lack of or burnout of caregiver/support;
- Multiple service use (i.e., a combination of physical, occupational and speech therapy);
- Significantly impaired in activities of daily living; and

- Complex cases requiring extensive (>3 hours) discharge planning.

Case management is initiated to assure appropriate utilization and timely delivery of quality health care for Members. Community First offers case management services for an individualized plan of health care, as well as targeted disease management programs for high utilization diagnoses. The purpose of case management is to promote the efficient and effective utilization of resources while assuring continuity and quality of care. All services are provided under the direction of the Member's PCP. Some case management candidates are initiated through a review of Community First's utilization data.

The functions of the Case Management Program are to:

- Identify appropriate candidates for case management services based on high-risk criteria (i.e., co-morbid illnesses, chronic illness, catastrophic diagnosis, no family support, etc.).
- Develop, coordinate and implement cost effective care plans for Members identified to be appropriate candidates.
- Serve as an advocate to coordinate and optimally utilize health care and community related services for the Member.
- Inform health care professionals, Members, and their families of available community services.
- Assist in the coordination of care with health care disciplines to promote the highest possible level of physical, psychological and social functioning for the member and family.
- Identify aberrant practices and submit to the appropriate personnel.
- Explain benefit coverage to Member and families.
- Facilitate linkages to appropriate community resources.

Community First Case Managers will work with the PCP and multidisciplinary team to facilitate the care plan. The Case Manager will request annual updates to ensure that the member needs are being met.

VII. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

A. Introduction

Our Quality Management and Improvement Program (QMIP) is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the health care delivery system. Components of this program include peer review, risk management, credentialing, compliance with external regulatory agencies, utilization review, medical records review, ongoing monitoring of key indicators, and health care services evaluation.

The purpose of our program is to assure the timely identification, assessment and resolution of known or suspected problems that may negatively impact the health and wellbeing of Community First Members.

The QMIP is under the supervision of the Vice President of Health Services Management, the Medical Director and the Quality Improvement Committee.

B. General Requirements of the QMIP

The success of the QMIP depends upon your cooperation by:

- Providing us with medical records concerning our Members upon request;
- Maintaining the confidentiality of Member information;
- Promptly responding to our phone calls or letters concerning Quality Management issues;
- Cooperating with our Quality Improvement Committee proceedings; and
- Participating on our Quality Improvement Committee, Credentials Committee, Utilization Management or Pharmacy and Therapeutics Committee, if appropriate. These committees consist of network providers who are board certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Network Management Representative.

Community First relies on the collection of data from numerous sources, including but not limited to: member satisfaction surveys, provider satisfaction surveys, claims data to help determine utilization trends, complaints, appeals and audits of clinical records and practice locations. Community First monitors utilization trends and quality issues for the entire network as well as for individual practitioners.

C. Credentialing and Recredentialing

For participation, all physicians must complete the Texas Standardized Credentialing Application for Physicians and undergo a careful review of their qualifications, including education and training, licensure status, board certification, and work and malpractice history. Practitioners have the right to review information submitted in support of their credentialing application and the right to correct erroneous information submitted by another party. Practitioners who meet the criteria and standards of Community First are presented to the Credentials Committee for final approval of their credentials. Community First will not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

Credentialing is required for all physicians and providers listed in the Community First directory. Physicians or providers who are members of a contracting group, such as an independent physician association or medical group, are credentialed individually. Credentialing is not required for: hospital-based physicians or individual providers, including advanced practice nurses and physicians' assistants, unless listed in the provider directory; individual providers who furnish services only under the direct supervision of a physician or another individual provider; students, residents, or fellows, and pharmacists.

Each physician and provider who initially applies to contract with Community First for the provision of health care services on behalf of Community First and who is denied a contract with Community First will be provided with written notice of the reasons the initial application was denied.

Recredentialing is performed at least every three years. In addition to the verification of current license, DEA certificate, malpractice insurance, National Practitioner Data Bank query and sanction activity by Medicare and Medicaid, the process will also include review of Member complaints and information from quality improvement activities.

D. Liability Insurance

Provider shall maintain, during the term of the Provider contract, Professional Liability Insurance of $200,000 per occurrence and $600,000 in the aggregate, or the limits required by the hospital at which Network Provider has admitting privileges.

[NOTE: This provision will not apply if the Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act.]

E. National Provider Identifier

All providers must have a National Provider Identifier (NPI). The NPI must be in place by May 23, 2007.

F. Facility Reviews

Community First conducts facility site reviews to evaluate the safety and appearance of the clinical facilities where care is provided to Community First Members, as well as to evaluate confidentiality, medical record keeping practices, and availability of appointments. The evaluation occurs in accordance with criteria developed by Community First. Facility site reviews are conducted:

- Prior to credentialing of Primary Care Physicians (PCPs), OB/Gyn and high volume individual behavioral health providers;
- Within three (3) years of the recredentialing process for all PCPs and high-volume individual behavioral health providers; and,
- When PCPs open new practice locations.

Should the site not conform to Community First's standards, a corrective action plan shall be requested, and a follow-up visit conducted every six months until thesite complies with the standards.

Community First may conduct a site visit to the office of any physician or provider at any time for cause. The site visit to evaluate the complaint or other precipitating event will be conducted by the appropriate personnel and may include, but not be limited to, an evaluation of any facilities or services relating to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

A copy of the **Provider Office Assessment Tool and Instructions (Exhibit 9)** are enclosed in this manual for your review.

G. Medical Record Reviews:

Community First conducts reviews of ambulatory medical records to evaluate record keeping systems and clinical documentation of the care provided to Members. The reviews are conducted by nurses from the Quality Management department and occur in accordance with medical record documentation standards approved by the Quality Improvement Committee. During the review, the nurse may determine when care is clinically appropriate; however, a practitioner must make any determination of inappropriate care. If potential qualities of care issues are identified, the case is referred to the Medical Director for further review.

During the initial credentialing process, medical records are reviewed only for medical record keeping practices for PCPs, OB/GYNs and high-volume individual behavioral health providers. Prior to recredentialing, medical records are reviewed for clinical documentation as well as medical record keeping practices for all PCPs and high-volume behavioral health practitioners. Medical record reviews may also be conducted at other times, as indicated. Clinical documentation audits include assessments of chart organization, appropriateness of clinical care, preventive health care, coordination of care, and completeness and comprehensiveness of documentation.

Reviews are conducted assessing performance against Community First medical records and preventive standards. Those practitioners with scores below the established benchmarks will be required to adopt a Corrective Action Plan. Follow-up reviews will be performed within six months to assess those areas identified that need action or process changes. If necessary improvements are not implemented within the specified time frame, it may be a breach of contract and may result in termination from the practitioner network.

Procedure: Community First nurses will:

1. Schedule an appointment in advance to conduct the facility and/or medical record review. At most times, the medical record review can occur at the same time as the facility site review.

2. Provide the audit tools and standards to the practitioner's office prior to the review, if requested.

3. Conduct the review according to Community First standards and document findings on approved data collection tools. A minimum of three (3) medical records per product type (i.e. Commercial, CHIP and Medicaid) per provider is reviewed.

4. Following the visit, provide a verbal summary of the findings to the practitioner or his/her designee.

5. Send a letter notifying the practitioner of the findings and requesting a corrective action plan if needed.

6. Perform follow-up reviews with offices that are non-compliant to ensure corrective action.

7. If the non-compliance is not corrected, forward the results to the Medical Director and/or the Quality Improvement Committee for review and interventions.

8. Perform interventions as directed.

9. Prepare an annual report for the Quality Improvement Committee identifying the number and types of reviews performed.

10. Aggregate data of all medical records performed during the year and analyze to assess opportunities for improvement and report to the Quality Improvement Committee.

A copy of the **Medical Record Audit Tool and the Medical Record Audit Criteria (Exhibit 10)** as well as the **Adult Pediatric Preventive Care Recommendations (Exhibit 11) and Adult Preventive Care Recommendations (Exhibit 12)** are enclosed in this manual for your review.

H. Physician Assistants and Advanced Practice Nurses

Community First requires practitioners who employ physician assistants, advanced practice nurses and individuals other than physicians to assess the health care needs of Community First Members, the practitioner must have written policies which are implemented and enforced and describe the duties of all delegation, collaboration, and supervision as appropriate.

Additionally, Certified Family Nurse Practitioners and Pediatric Nurse Practitioners must:

1. Be licensed by the Texas State Board of Nurse Examiners or other state licensing authority;

2. Be recognized by the licensing authority as an advanced nurse practitioner;

3. Comply with all applicable federal and state laws and regulations governing the services provided;

4. Be enrolled and approved for participation with Community First;

5. Prefer that each member treated by a group physician assistant or advanced practice nurse sign a **Consent to use Physician's Assistant/Nurse Practitioner (Exhibit 13)**

6. Comply with the terms of the provider agreement, including regulations, rules, handbooks, standards and guidelines published by Community First;

7. Bill for services covered by Community First in the manner and format required by Community First Claims Administration Program.

    a. Subject to the specifications, conditions, requirements and

limitations established by Community First, services performed by advanced nurse practitioners are covered if the services:

i. Are within the scope of practice for advanced nurse practitioners, as defined by state law;

ii. Are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate licensing authority; and

iii. Would be covered by Community First if provided by a licensed physician (MD or DO)

b. To be payable, services must be reasonable and medically necessary as determined by Community First.

c. Advanced nurse practitioners who are employed or remunerated by a physician, hospital, facility or other provider must not bill Community First directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by Community First Health Plans, payment may be made to the physician, hospital, or other provider (if the provider is approved for participation with Community First) who employs or reimburses advanced nurse practitioners. The basis and amount of reimbursement depend on the services actually provided, who provided the services, and the reimbursement methodology determined by Community First as appropriate for the services and the providers involved.

I. Practice Guideline Development

In an effort to provide and maintain quality health care and preventive service, Community First has established a process for evaluating patterns of care for specific conditions and procedures. Adult and Pediatric Preventive Care Guidelines have been developed by the Quality Improvement Committee. Compliance with the guidelines is evaluated during the medical record review process.

Performance measurement activities are conducted at least annually for selected aspects of the guidelines and may include claims review or medical record data abstraction. The National Committee for Quality Assurance (NCQA) and the Health Plan Employer Data Information Set (HEDIS®) are examples of performance measurement activities that provide feedback on the levels of preventive health services received by Members. Community First uses these performance measurement results to identify Members at risk for specific health

problems and to inform their practitioners that health promotion and prevention services may be needed.

The Quality Improvement Committee has also approved clinical practice guidelines for acute and chronic medical illnesses that are adopted using national standards that are current and evidence based. Examples of such guidelines include asthma, prenatal care, depression and attention-deficit/hyperactivity disorder. Selected measures are measured annually, and quality improvement activities are implemented as appropriate. Practice guidelines are available on the Community First website at www.CommunityFirstHealthPlans.com.

J. Confidentiality

All information used for quality improvement activities will be maintained as confidential in accordance with applicable federal and state laws and regulations. Employees, Quality Improvement Committee participants and subcommittee participants will sign a Confidentiality Statement and will be held accountable for compliance with the Community First Confidentiality Policy. Quality Improvement Committee and related subcommittee minutes will be kept in a secure and locked location.

K. Conflict of Interest

No person may participate in the review, evaluation, or final decision in which he or she has been professionally involved or where judgment may be compromised.

L. PCP Availability and Accessibility Standards

1. Participating PCPs (or their designated physician coverage) and referral specialists are to be available and accessible to Members 24 hours per day, 7 days per week within the Community First service area. There is to be telephone access to PCPs (or their designated physician coverage) at all times. The following are acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

   Acceptable:

   a. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

   b. Office phone is answered after normal business hours by a recording, in the language of each of the major population groups served, directing the patient to call another number to reach the

PCP or another network provider designated by the PCP. Someone must be available to answer the designated network provider's phone. Another recording is not acceptable.

c. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the PCP or another designated network provider.

Unacceptable:

a. The office phone is only answered during office hours.

b. The office phone is answered after hours by a recording, which tells patients to leave a message.

c. The office phone is answered after hours by a recording that directs patients to go to an emergency room for any services needed.

2. **Access Standards**

Community First's access standards are referenced in **(Exhibit 14)**.

VIII. PREVENTIVE HEALTH & DISEASE MANAGEMENT

Members who feel empowered to become knowledgeable partners in their health care are better able to accept responsibility for appropriate utilization of health care resources. With that in mind, Community First has developed programs which work within the continuum of health to promote health, primary prevention, early detection and treatment, and disease management. Our goal is to promote a collaborative relationship between our members and their health care providers, in order to create a supportive environment for the development and maintenance of healthy lifestyle behaviors.

A. Provider Referral

Providers are encouraged to inform Members about the health education services available through Community First. When an education or social need is identified, one can refer a Member to the Preventive Health & Disease Management Department one of four ways:

1. Mail in the **Member Education Request Form (Exhibit 15)** to:

Community First Health Plans, Inc.
Network Management
12238 Silicon Drive, Ste. 100
San Antonio, TX 78249

2. Fax the **Member Education Request Form** to Network Management at **(210) 358-6199**.

3. Contact a Community First Health Educator at **(210) 358-6144** or **(210) 358-6145**.

4. The standard Authorization form for Community First may also be completed and mailed in or faxed to request Preventive Health & Disease Management outreach.

B. Health Education Services

Health education is available through classes, educational mail outs and individualized outreach visits. Several initiatives have been developed to educate members and promote involvement in self-care behaviors. Participation in disease management and health promotion initiatives is free-of-charge. Overall program goals include increased education regarding disease processes and management, establishment of a collaborative physician-patient relationship, appropriate utilization of health care resources, increased quality of life and member satisfaction and retention. Program participation information is routinely mailed to the primary care physician for review and inclusion in the member's medical record.

Diabetes Disease Management

Community First developed an initiative to identify members who have diabetes and to promote diabetes education and self-management skills with an emphasis on the development of a physician-patient collaborative approach to diabetes care. The program goals include ongoing education regarding diabetes standards of care, formal diabetes education, access to diabetes equipment and supplies and the member's role in preventing diabetes complications.

Asthma Disease Management

Asthma*Matters* is an initiative developed by Community First to improve the health,

well-being and productivity of our members with asthma through quality health promotion and education services in collaboration with our members, physicians and community organizations. A key element of the program is to promote the development of a strong collaborative relationship between our members and their primary care providers and the use of nationally accepted care standards for asthma to help members achieve long-term control of their disease.

Upon identification of prospective members, steps are taken to assess asthma severity levels and implement appropriate education and outreach services for each member. Asthma education literature is mailed to members throughout the year to provide ongoing information that promotes asthma control and knowledge about the disease. Formalized education classes and intensive risk assessment and disease management services are coordinated with existing community programs, to promote utilization of existing community services.

Prenatal Education Program

Community First is committed to improving health outcomes for the gestational woman and her baby. The Preventive Health & Disease Management and Case Management staff collaborates with health plan physicians to promote access to early and ongoing prenatal care, completion of the prenatal course up to the postpartum visit, assignment of a pediatrician prior to birth and utilization of preventive health care services for the newborn.

Through outreach to women identified to be pregnant, Health Educators and nurses assess potential risk factors, develop an individualized action plan and track member progress over the gestational course. Prenatal education classes are provided free-of-charge to health plan members at locations throughout the service area. The courses provide a venue for members to learn about the growth and development of the fetus and ask questions in a group format. Clinical outreach staff provides ongoing support and education to those identified to be at higher risk for adverse pregnancy outcomes.

Children with Complex Special Health Care Needs (CCSHCN) Program

In the past several years, Community First has worked with the Texas Department of Health and the Center for Health Care Strategies to identify children with complex special health care needs. If a member with a complex special health care need is identified, clinical staff is available to assess health care needs of the member and assist in accessing health care services needed. Outreach mechanisms have been developed to assess member's physical, developmental,

behavioral, and/or emotional health conditions and the need for care coordination and case management services.

Community First staff is available to outreach to Community First commercial members at the physician's request, to detect health risk factors, assess potential participation in population-based initiatives or disease management programs and to assess barriers to care. An individualized care plan will be initiated for each member who accepts case management services. Educational information and resource information, including social services resources, is given to members. Although not all social concerns are directly related to their medical care, frequently these issues affect access to care, continuity of care and compliance with treatment plan. Community First works to assist members in addressing these concerns in order to promote wellness. Information gathered from the member is forwarded to the primary care physician for review, potential outreach and inclusion in the medical record.

In 2002, Community First conducted a survey of primary care provider needs regarding care coordination, access to Community First's case management services, community-based services and federal/state benefit programs. Physicians expressed interest in having a standard care plan, which can be individualized for each patient. A care plan has been developed and is included as **Care Plan for Children with Complex Special Health Care Needs (Exhibit 16)**. Community First will also develop a local social services resource guide for physicians, which will be included in the Referral Directory.

If you are caring for a child with special health care needs and would like assistance in coordinating a multi-disciplinary care plan or case management services, please fax your referral to the Utilization Management department at **(210) 358-6040**.

IX. BILLING AND CLAIM ADMINISTRATION

Important information regarding billing and payment of claims is also contained in Article III of your Provider Agreement with Community First.

A. Submission of Claims

The address for submitting Community First HMO claims is:

Claims Department
Community First Health Plans, Inc.
12238 Silicon Drive, Ste. 100
San Antonio, TX 78249

Direct any questions regarding claims to Community First's Claims Customer Service Department at **(210) 358-6200.**

Community First receives a significant number of paper claims on a monthly basis. Our goal is to process your claims as quickly as possible. To expedite claim processing, we are asking your assistance with the following:

1. Submit paper claims through normal mail delivery **unless** you are in jeopardy of missing the filing deadline and you require proof of timely filing.

2. Use 10"X13" envelopes; send multiple claims in one envelope.

3. Do not staple, paper clip or fold claim forms or attachments.

4. Do not use red ink.

5. Claims must be legible and scannable. Handwritten claims are difficult toscan.

6. Change your printer ribbon frequently so information on the claim is visible and can be scanned.

7. When printing your claim forms, make sure the printer is online and the information prints within the correct field.

Community First HMO claims are processed within 30 days of receipt of the claim.

Physician, DME and supplies, and ambulance claims must be filed on a red line **CMS-1500 (Exhibit 17)** claim form**.** Hospital, Rural Health Centers and Home Health claims must be filed on a **UB-04 (Exhibit 18)**.

To be considered a clean claim, the red line CMS-1500 or the UB-04, as applicable, must include the minimum elements for such claim forms required by Texas Department of Insurance regulations in 28 Texas Administrative Code (TAC) §21.2803, as amended from time to time, as required by any statute or regulation that may supersede 28 TAC §21.2803. If Community First requires additional elements or attachments, it shall give providers at least 90 days' notice of the additional requirements.

Note: When billing outpatient surgery revenue codes on a UB-04 claim form (Exhibit 18) the corresponding CPT- 4 procedure code must also be billed. The CPT-4 procedure code must be specific, unlisted codes are not acceptable.

Only claims including all required information are considered clean claims.

Claims for Community First should be billed with the normal fees you would charge in the absence of a contract with a health plan. Community First will make the

appropriate adjustments per its contract with you, if necessary, and will show any adjustments made on the Explanation of Payment sent to you with your reimbursement check.

B. Filing Deadlines:

1. Community First must receive clean claims for Community First Commercial HMO within ninety-five (95) days of the date of service.

2. Claims received after the filing deadline will be denied payment.

C. Proof of Timely Filing:

1. Community First accepts the following as proof of timely filing:

   - Certified mail receipt

   - Dated fax transmission confirmation with Community First fax number

   - Electronic confirmation from Availity

   - Log listing claims with member name and date of service if signed by both the provider and a Community First representative.

D. Appeal Deadlines:

1. Providers have the right to appeal the adjudication of a claim denied by Community First. Community First HMO appeals must be received by Community First within sixty (60**)** days of the date of the **ORIGINAL** Explanation of Payment.

2. All appeals and/or corrected claims must indicate such on the claim. **Community First will not accept an appeal submitted after the appeal deadline.**

3. Resubmission of a claim without correcting the claim as identified on the EOP is not considered an appeal.

4. Methods available to appeal a claim are:

   - Telephonically through the claims customer service center at (**210) 358-6200**.

   - In writing to Community First at:

     Community First Health Plans, Inc.

Attention Claims Appeal
12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249

- In writing through your Network Management Representative.

- In writing through the Health Services Management Department, if related to a notification or authorization issue

- Via fax to **(210) 358-6014**

E. Electronic Data Interface (EDI)

1. The preferred method of receipt of claims is electronically through EDI. Community First uses Availity (www.availity.com) as the intermediary.

2. Community First's Availity payor ID Number is COMMF.

3. An Availity reference guide detailing the specifics of submission is available by calling 904-470-4900 or 800-AVAILITY (282.4548).

4. You will receive a response report within 24 hours after a successful transmission. The report will indicate the claims that were accepted and the claims that were rejected. **The rejection information on the response report is the only notification you will receive that the claim was rejected and the reason for rejection. It is imperative that you read and understand the response report**. **An unsuccessful transmission is not considered proof of timely filing with Community First.**

5. Providers also have the option of submitting electronic claims via WebMD. For more information about the electronic filing through WebMD, please contact WebMD directly at **1-800-845-6592**.

6. Community First will provide written notice at least 30 days prior to changes in EDI vendors.

As of October 16, 2003, health plans and providers who submit any claims electronically must comply with federal regulations adopted under HIPAA and governing the standardization of core health care transactions, including claims submission. Health care clearinghouses will also be required to comply with the regulations, and providers may comply through contracting with a clearinghouse to ensure that standardized information is submitted to Community First. As Community First implements this regulation and modifies its own processes, it will provide you notice of how such modifications affect the claims submission process.

F. Negative Balances

1. Community First has the right to recover overpayments made to providers.

2. If a negative balance exists on an EOP, maintain a copy of the EOP for future reference.

G. Coordination of Benefits

1. A third party may be liable for some or all of the member's medical care (i.e., auto liability, disability, or workers' compensation).

2. In situations where a member has other insurance, the other insurance carrier may be the primary payer.

3. The third-party insurance (primary carrier) must be billed first. After receipt of the EOB, attach a copy of the Explanation of Benefits (EOB) received from the other insurance carrier and submit the claim to Community First.

4. The claim must be filed to Community First within sixty (60) days of the date of the other insurance EOB. Community First will deny payment on claims that do not include proof of prior filing with the member's other insurance.

5. If Community First pays an amount that should have been paid by another carrier, Community First will recover overpaid amounts.

6. Authorization must be obtained for those services that require an authorization (see Section IV, Utilization Management), even when Community First is a secondary payer to any other insurance carrier including Medicare.

H. Explanation of Payment (EOP)

1. You will receive an explanation of payment form **(Exhibit 19)** detailing:

   - Date of Service
   - Place of Service (location code)
   - Diagnosis code
   - Procedure code
   - Modifier

- Type of Service
- Days/count
- Amount billed
- Allowed (contracted) amount
- Deductible/Copay amount
- Other insurance payment (TPP)
- Amount Denied
- Total benefit paid to the provider
- Reason(s) for denial or nonpayment (Explain codes)

2. **It is imperative that you review your EOP to determine the reason(s) for the denial. If you do not review your EOP you will jeopardize your opportunity for appeal.**
3. If negative services balance exists on the EOP, maintain a copy for future reference.
4. The address page of the EOP will also be used for messages to providers that are of significance for claims submission and payment.

I. EOP and Duplicate Checks and Cancelled Check Requests

Community First receives a significant number of requests each month from providers for additional copies of EOPs and canceled checks. The provider is sent a copy of the EOP with each check issued by Community First. It is the responsibility of each provider's office to keep this information available for use in posting payments and submitting appeals. We recommend that you make a copy of the check, both front and back, as well as a copy of the EOP, so you have it available should you need in the future.

Check printing errors that result in duplicated checks should be reported to Community First Health Plans as soon as identified. Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed. Any bank fees that provider accrues after provider deposits or cashes a duplicate check will not be reimbursed by Community First Health Plans.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of $15.00 per OP and $20.00 per check. The request for a copy of the EOP and/or check must be submitted in writing along with the appropriate fee. The request must include the

date of the EOP, the name of provider, and date of the check. Send the request to:

Community First Health Plans, Inc.
Attention Claims Department Secretary
12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249

J. IntelliClaim

All physician and provider claims submitted to Community First are audited by IntelliClaim as part of the claims adjudication process.

The analysis by IntelliClaim is based on procedure rules and coding schemes developed by the AMA and found in CPT-4 & ICD-9 manuals as they apply to medicine, surgery, radiology, laboratory, pathology and anesthesiology services. Many other resources also were used by IntelliClaim to develop the auditing system such as CCI (Correct Coding Initiative), CMS, specialty societies and specialty consultants. Its developers update IntelliClaim annually, as new editions of CPT & ICD manuals become available.

IntelliClaim provides consistent and objective claim review. Some of the common oversights IntelliClaim will identify are:

- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral or duplicate procedures
- Pre- and post-operative care unbundling
- Single code conflicts
- Assistant surgeon conflicts
- Procedures bundling

K. Provider Under Investigation

Community First will not pay claims submitted for payment by a provider who is under investigation or has been excluded or suspended from the Medicare or Medicaid programs for fraud and abuse, when Community First has been notified of such investigation, exclusion or suspension.

L. Claims Payment

The method of payment applicable to Providers are documented in the Compensation Section of the Community First Professional Provider Agreement.

X. WASTE, ABUSE & FRAUD

Provider understands and agrees to the following:

- Community First and/or the Office of Inspector General ("OIG") must be allowed to conduct private interviews of Providers and their employees, agents, contractors, and patients;
- Requests for information from such entities must be complied with, in the form and language requested;
- Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense; and
- Compliance with these requirements will be at the (Provider's) own expense.

Provider understands and agrees to the following:

- Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care;
- Providers must cooperate and assist any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
- Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, Federal Bureau of Investigation, Texas Department of Insurance, Texas Attorney General's Office, Office of the Inspector General or other unit of state or federal government, upon request, and free-of-charge;
- If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and

- Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by Community First or a Member to the Office of Inspector General.

A. Special Investigation Unit

Corporate Statement

In response to rules enacted on May 13, 2004, by the State of Texas under Title 1, Chapter 353, a Special Investigation Unit (SIU) has been established by Community First.

Community First is committed to protect and preserve the integrity and availability of health care resources to our members, our healthcare partners and the general community. Community First performs these activities through its Special Investigation Unit (SIU) to detect, prevent and eliminate waste, abuse and fraud at the provider, member and health plan level. Community First utilizes electronic systems and training of our employees, contractors and agents to identify and report possible acts of waste, abuse and fraud. When such acts are identified, Community First seeks effective remedies to identify overpaid amounts; recover identified amounts, prevent future occurrences of waste, abuse and fraud; and report offenses to the appropriate agencies when necessary.

Acts of **waste** are defined as activities involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent but that the outcome of poor or inefficient methods results in unnecessary costs to Community First.

Acts of **abuse** are defined as activities that unjustly enrich a person through the receipt of benefit payments but where the intent to deceive is not present, or an attempt by an individual to unjustly obtain a benefit payment.

Fraud is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.

Community First considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjustly benefit payments is not considered unless there is documented previous education in writing or in person by Community First regarding the same or similar adverse audit findings or there are obvious program violations.

Procedures for detecting possible acts of waste, abuse or fraud by providers:

Audits

The SIU performs audits to monitor compliance and assist in detecting and identifying possible violations and waste, abuse, and fraud overpayments through:

1. Data matching – procedures, treatments, supplies, tests, and other services as

well as diagnosis billed are compared for reasonableness using available sources including the American Medical Association (AMA), Centers for Medicare/Medicaid Services. Comparisons include age, gender, and specialty when applicable.

2. Analysis – inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of providers' activities lists outliers based on particular specialty and across all specialties and includes procedures, modifiers, and diagnosis. Pharmacy data may be reviewed if provided in usable format by Community First's pharmacy benefits manager.

3. Trending and Statistical Activities – The SIU uses EDI Watch software to build provider profiles that show trends and patterns of submissions based on key claim elements and includes providers' patient activities. Statistical analysis shows provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

Monitoring

The SIU monitors patterns for providers, subcontractors and facilities submitting claims. The monitor results list outliers based on claims submissions and utilization. Any provider that is flagged for certain payment patterns is also examined for other flags to paint an overall profile. Recipients with flags will be examined for other flags as well and to evaluate patient-provider relationships.

Hotline

Community First maintains an anti-fraud hotline, at (210) 358-6332 to allow reporting of potential or suspected violations of waste, abuse and fraud by members, providers and employees. A recording device is utilized to capture calls. Messages left on the recording device are answered by SIU personnel within two business days. The hotline number is printed on appropriate member and provider communications and published on the Community First website. The hotline number is also included in Community First provider and member handbooks. The SIU maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

Random Payment Review

The profiling and statistical analysis is performed on a random selection of claims submitted by providers for reimbursement by varying criteria to detect potential overpayment. The queries include a random function to create the reports on different blocks of data and apply them toward flagged claims.

Edits

Community First Health Plans utilizes claim-editing software (IntelliClaim) to prevent payment for fraudulent or abusive claims. It is an established and widely used clinically based auditing software system that verifies the coding accuracy of professional service claims.

These edits include specific elements of a claim such as procedure, modifier, diagnosis, age, gender, or dosage. Community First applies the edits through its claims adjudication system. The edits are commonly accepted and verifiable filters including the national guidelines published by CMS, CCI, OIG and AMA.

Routine Validation

Community First provides our vendor, EDI Watch with three years of claims data. EDI Watch processes the electronic claims data on a quarterly basis. EDI Watch supplies a data load to the SIU, which applies edits, flags, fraud rules, and build routine activity profiles. These routine validations produce:

- Summary of Findings – A high level of flags and potential overpayment across all claims to identify major areas of concern.
- Triage Reports – List of providers that are in the high percentile of flags and/or utilizations on which Community First can focus.
- Detail Reports – Provide details supporting the profile activities of a provider or patient.

Procedures for detecting possible acts of waste, abuse or fraud by members:

The SIU utilizes software flags for detecting possible acts of waste, abuse or fraud by Community First members. Flags include:

- Treatments and procedures that appear to be duplicative, excessive or contraindicated by more than one provider, i.e., same patient, same date-of-service, same procedure code.
- Medications that appear to be prescribed by more than one provider, i.e., same patient, same date-of-service, and same NDC code.
- Members that appear to receive excessive medications higher than average dosage for the medication.
- Compare the Primary Care Provider (PCP) relationship code to the recipient to evaluate if other providers and not the PCP are treating the recipient for the same diagnosis.
- Identify members with higher-than-average emergency room visits with a

non-emergent diagnosis.

The SIU utilizes Community First specialty codes to identify psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists. The software flags can detect by specialty code possible overuse and/or abuse of psychotropic and /or controlled medications by recipients who are treated by two or more physicians at least monthly.

The SIU requests medical records for the recipients in question if claim data review does not clearly determine evidence of overpayment. Upon the receipt of the records from the provider, the SIU reviews the documentation for appropriateness.

Procedures for Determining General Overpayments:

- Compliance audits
- Monitoring of service patterns
- Random payment review of claims
- Routine validation of claim payments
- Pre-payment review
- Review of medical records
- Focused reviews
- Review of claim edits or other evaluation techniques
- Itemized hospital bill reviews

Findings that are considered general overpayments include the following:

- Billing errors
- Insufficient documentation to support billed charges
- Inappropriate use of modifiers
- Incorrect billing provider
- Duplicates
- Billing for different authorized services

- Data matching of diagnosis and procedure codes
- Unbundling of services, procedures and/or supplies
- Claim processing errors

Time limitation for review of general overpayments:

- Recovery of discovered general overpayments will be initiated for a minimum of two years in which the explanation of original payment was made.
- Only the year of the payment and the year it was found to be a general overpayment enter into the determination of the calendar year period. The day and the month are irrelevant.
- Clear evidence of intentional fraud, waste, abuse or program violation is excluded from general overpayment reviews.
- Preliminary investigations and full investigations are excluded from determining general overpayment findings.

Consideration of general overpayments is determined when the following has not occurred previously:

- Previous investigation or report of fraud, waste or abuse by **Community First** related to same or similar findings
- Educational training by **Community First** related to same or similar findings
- Clear evidence of intentional fraud, waste, abuse or program violation,
- Clear pattern of billing errors has occurred.

Procedures for SIU Overpayment Recovery Process

The SIU has established the following process regarding recovery of overpayments discovered through investigations including preliminary investigations.

Overpayments will be processed in the following manner:

- Upon completion of the investigation and final disposition of any administrative, civil, or criminal action taken by the state or federal government, Community First SIU will determine and direct the collection of any overpayment.

- Overpayments collected as a result of an investigation will be distributed to Community First unless an alternative distribution is indicated.

- If Community First is not entitled to all or any portion of the distribution of funds collected as a result of an overpayment, the appropriate regulatory agency will provide Community First with a written explanation indicating the rationale for the alternative distribution of funds.

- The minimum dollar threshold for referral to the OIG is $5,000. Community First will also refer Providers to the appropriate regulatory agency with less than $5,000 in error if there is clear evidence of intentional conduct that indicates a pattern of fraud, waste or abuse.

- Community First provides education to providers and documents educational efforts regarding audit findings and coding compliance.

- Community First SIU recovers overpayments discovered by auditing and monitoring efforts (less than $5,000) via claims adjustments and accounts for these recoveries in cost reports.

The Community First SIU has established the following process regarding recovery of general overpayments discovered through reviews and audits excluding investigations.

Commercial HMO program general overpayments will be processed in the following manner:

- Notification of overpayments will occur after the completion of an audit, or review.

- Be in writing and include the specific claims and amounts for which a refund is due.

- Provide the basis and specific reasons for the request for refund.

- Include notice of the physician's or provider's right to appeal.

- Describe the method and due date by which the refund will occur.

- Describe actions that will occur if overpayment is not refunded.

Commercial/HMO program general overpayment appeal process:

- A physician or provider may appeal a request for refund by providing written notice of disagreement of the refund request not later than 45 days after receipt of overpayment notice.
- Upon receipt of written notice, the SIU shall begin the appeal process as provided in the contract with the physician or provider.
- A refund will not be recouped until:
- the later of the 45th day after overpayment notification;
- the physician or provider has made arrangements for payment with the SIU prior to the 45th day overpayment notification;
- exhaustion of any physician or provider appeal rights according to the physician or provider contract and/or documented attempts to recover the overpayment.
- The appeal process does not apply in cases of fraud or a material misrepresentation by a practitioner or provider. Fraud is considered and noted as intentional after a practitioner or provider has been previously educated in writing or in person by Community First regarding the same or similar audit, review or investigational findings or there is reasonable clear evidence of intent.

Non voluntary repayment of overpayments will result in any or all of the following actions:

- Recoupment of overpayment from future claims
- Payment hold
- Termination from the Community First provider network
- Referral to the appropriate regulatory agency.

Time limitation for recovery of overpayments:

- Recovery of discovered overpayments will be initiated from a minimum two-year period in which explanation of original payment was made.
- Only the year of the payment and the year it was found to be an overpayment enter into the determination of the calendar year period. The day and the month are irrelevant.

Provider and recipient fraud, waste and abuse education

- Members and providers are offered fraud, waste and abuse education through a variety of avenues such as the Community First website, member and provider newsletters, provider manuals, and member handbook. The information contained in the material includes the definitions and examples of fraud, waste and abuse and how to report fraud, waste and abuse.

Provider newsletters also offer compliant coding and medical record documentation tips.

Consistent with Section 6032 of the Deficit Reduction Act of 2005, Community First has established guidance to educate recipients, providers, employees, contractors and agents regarding the reporting of fraud, waste or abuse. For clarification purposes, contractors and agents are defined by CMS as "one which, or one who, on behalf of Community First, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care".

Medical Record Standards:

Community First follows 1997 CMS and current *American Medical Association (AMA) Current Procedural Terminology (CPT)* documentation and coding guidelines as stated in the Texas Medicaid Provider Procedures Manual.

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandate the use of national coding and trans-action standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

Amendment of Medical Records

Community First follows the Texas Administrative Code, Title 22, Part 9 Charter 165 Rule
§165.1 guidelines for the amendment of medical records.

- The provider must have specific recollection of the services provided which is documented.

- A provider may add a missing signature without a time restriction if the provider created the original documentation him/herself.

- The above does not restrict or limit the provider's ability to document or amend medical records at any time to more accurately describe the clinical care provided to the patient.

- For medical record review/audit and reimbursement purposes, documentation is not considered appropriate and/or timely documented if originally completed after thirty (30) days of the date of service.

DEFINITIONS:

Late entry: supplies additional information that was omitted from the original entry. The late entry is added as soon as possible, reflects the current date and is documented and signed by the performing provider who must have total recollection of the service provided.

Addendum: provides additional information that was not available at the time of the original entry. The addendum should be timely, reflect the current date, provider signature and the rational for the addition or clarification of being added to the medical record.

Correction: revisions of errors from the original entry which make clear the specific change made, the date of the change and the identity of the person making the revision. Errors must have a single line through the incorrect information that allows the original entry to remain legible. The correct information should be documented in the next line or space with the current date and time, making reference back to the original entry.

Behavioral Health Medical Records

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their record:

- All entries are clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider

- Notations of the beginning and ending session times for counseling and/or each test administered.

- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:

- Name of test(s) (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI]).
- Background and history of client and reason for testing. Behavioral observations during the session.
- Narrative description of the counseling session or test findings. Diagnosis (symptoms, impressions).
- Treatment plan and recommendations.
- Explanation to substantiate the necessity of retesting, if applicable.

Reporting Provider/Recipient Fraud, Waste and Abuse

Community First has established several mechanisms that can be utilized for the reporting of suspected acts of waste, abuse and fraud. The **Suspicious Activity Report (SAR) Form for a Member (Exhibit 20) and Suspicious Activity Report (SAR) Form for a Provider (Exhibit 21)** are available and may be requested by your provider relations representative. Suspicious activity may be reported as follows:

In writing:

Community First Health Plans Inc.
ATTN: Special Investigations Unit
12238 Silicon Drive, Ste. 100
San Antonio, TX 78249

By calling:

Fraud Waste and Abuse Hotline message center: (210) 358-6332
Or, Community First Health Plans Inc. toll free # 1-800-434-2347

XI APPEALS

A. Adverse Determination

If you wish to appeal a decision made by Community First that the health care services proposed to be furnished or furnished to a member are not medically necessary, you or the member may appeal the Adverse Determination orally or in writing.

Please adhere to the following process when appealing an Adverse Determination:

1. Within five working days from receipt of the appeal, Community First will send the appealing party a letter acknowledging the date of Community

First's receipt of the appeal. This letter will include a reasonable list of documents that need to be submitted to Community First for the appeal.

2. When Community First receives an oral appeal of adverse determination, Community First will send the appealing party a one-page appeal form.

3. Emergency care denials, denials for care of life-threatening conditions, and denials of continued stays for hospitalized patients can follow an expedited appeal procedure. This procedure will include a review by a health care provider who has not previously reviewed the case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

4. The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one working day following the date that the appeal, including all necessary information to complete the appeal, is made to Community First.

5. After Community First has reviewed the appeal of the Adverse Determination, Community First will provide written notification to the member and the member's physician or health care provider explaining the resolution of the appeal. Community First will provide written notification to the appealing party as soon as possible, but no later than thirty (30) days after we receive the written appeal or completed appeal form. The notification will include:

    a. A clear and concise statement of the specific medical or contractual reason for the resolution.

    b. The clinical basis for such decision.

    c. The specialty of any physician or other provider consultant.

    d. If the appeal is denied, the written notification will include notice of the appealing party's right to seek a review through a Independent Review Organization (IRO) (See Member Complaints and Appeals section).

    e. Denials for care of life-threatening conditions can be appealed directly to the Independent Review Organization as outlined in the denial letter.

Please Note: This decision affects coverage only and does not control whether to render medical services.

B. Claim Denials

Providers have the right to appeal a claim denied by Community First. Providers have sixty (**60) days** from the date of Community First's Explanation of Payment to appeal the denial. Community First's Claims Department will not accept any appeal(s) received after the appeals deadline. Providers must mail the appeal to Community First's Claims Resolution Department:

Community First Health Plans, Inc.
Attention Claims Resolution Department
12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249
Phone: (210) 358-6200

Community First **Claims Department Appeal Submission Form (Exhibit 22)** may be used when submitting appeal. Please direct any questions regarding appeals to Community First's Claims Department at (**210) 358-6080**.

C. Member Complaints and Appeals

If a member has any kind of problem or concern regarding the delivery of their health care, they can call our Member Services Department any time of the day or night at **(210) 358-6060** / **1-800-434-2347** or TDD **(210) 358-6080**. A Member Services representative will help the member with any issues and concerns the member may have.

D. Appeals of "For Cause" Termination of Community First HMO Agreement

According to your agreement with Community First, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If we give you a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure. This procedure is available only if we are terminating your agreement for the reasons stated above.

1. Notice of Proposed Action

Community First will give you notice that your agreement is about to terminate or has terminated, and the reason(s) for the termination. The notice will either accompany your sixty (60) day notice of termination, or be given at the time your agreement terminates immediately without notice.

Upon termination of your agreement, you may file an appeal with Community First's Medical Director by registered or certified mail within

thirty (30) days of receiving the notice of termination. You should include any explanation or other information with your request for appeal. Community First's Medical Director will appoint a committee to review your request and any additional information or explanation provided within thirty (30) days of receipt. The committee will make a recommendation to Community First to reaffirm your agreement or reaffirm your agreement with sanctions or uphold your termination.

2. Decision

Within ten (10) days of the Board of Directors decision, Community First will, by registered or certified mail, inform you of Community First's Board of Directors decision on your request for appeal. This decision will be final.

E. Provider Complaints and Appeals

Community First has a process to address provider complaints in a timely manner, which is consistent for all network providers. Community First and the provider have an obligation under their mutual contract provisions to make a good faith effort to resolve any disputes arising under the agreement. In the event a dispute cannot be resolved through informal discussions, the provider must submit a complaint to Community First, which specifically sets forth the basis of the complaint along with a proposed resolution. Providers should submit complaints, verbally or in writing, to Community First's Network Management Department.

Provider understands and agrees that the Texas Department of Insurance reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into provider complaints.

1. Provider Complaint

Upon receipt of a written provider complaint, the Network Management Department will send a letter acknowledging receipt of the complaint within three (3) working days from the date of receipt. If the provider complaint is received orally, the Network Management Department will send a **Provider Complaint Form** with a transmittal letter **(Exhibit 23)**. The provider must complete the form and return the form to Community First's Network Management Department for prompt resolution of the complaint. Once the Provider Complaint Form is received by Community First's Network Management Department, a letter will be sent acknowledging receipt of the complaint within three (3) working days from the date of the receipt.

2. Appeals

Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First's resolution of the complaint to the provider within thirty (30) calendar days from the receipt of the written complaint or completed Provider Complaint Form.

If the provider and Community First are unable to resolve the complaint, the provider may submit an appeal, orally or in writing, to Community First. Upon receipt of a written appeal, Community First will send a letter acknowledging the request for an appeal within three (3) working days from the date of receipt. If the appeal is received orally, Community First's Network Management Department we will send an **Appeal form (Exhibit 24)** for the provider to complete and return to Community First.

Community First will send written notification within thirty (30) calendar days from the receipt of the appeal to the provider of the acceptance, rejection or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First's final determination. The notification will advise the provider of his or her right to submit the appeal to binding arbitration. Any binding arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association, unless the provider and Community First mutually agree to some other binding arbitration procedure.

PROVIDER MANUAL
Commercial HMO Plan

12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249
CommunityFirstHealthPlans.com