

PROVIDER'S RESPONSIBILITIES AND COMPENSATION

Section II

I. PRIMARY CARE PROVIDER'S ROLE

Each member of Community Health Plan selects a Primary Care Provider (PCP) who serves as the member's personal physician/provider and is responsible for managing all aspects of that member's medical care. Family and general practitioners, internists, pediatricians, advanced nurse practitioners, and physician assistants may be primary care providers. Specialists may be designated as primary care providers only in special circumstances and after approval from Community Health Plan.

At the time of enrollment, each member selects a PCP from a designated listing of primary care providers. Members of the same family may select different primary care providers. All medical care must be provided either by or upon the referral of that primary care provider with the following exceptions:

For groups with chiropractic benefits, chiropractic services may be accessed up to the benefit maximum without PCP approval.

Women may self-refer to a participating OB/GYN provider once a calendar year for a well-woman exam and any time for gynecological problems.

Members who have a vision rider may self-refer to a participating VSP optometrist as specified.

Members with diagnosed diabetes may directly access an in network ophthalmologist for an annual dilated retinal exam.

Member-requested services obtained without a referral from the member's PCP will be the provider's financial responsibility and not that of Community Health Plan or the member, unless the member has Point of Service, Community Choice, or Gold Plus products. Members may self refer to participating providers under those plans, at a reduced benefit level. Community Health Plan members **cannot** be held financially responsible without Community Health Plan authorization.

II. PRIMARY CARE PROVIDER RESPONSIBILITIES

- Maintain continuity, coordination, and comprehensiveness of each member's health care by serving as the manager of all medical services.
- Obtain prior authorization from Community Health Plan before performing all items that are listed on the Prior-Authorization List.
- Prior authorization for all non-participating provider care including non-participating, consulting or referral provider, ancillary, and facility providers.
- Work closely with consulting providers to enhance continuity of medical care and develop appropriate treatment programs. A Coordination of Care form, to facilitate this process, is available in the Provider section of our web site at www.mychp.com.
- Facilitate quality and cost-effectiveness of referrals by providing pertinent medical records (including results of diagnostic studies performed) to the consulting provider.
- Submit completed claims to Community Health Plan per terms of your contract.
- Collect specified payments from members.
- Maintain current member medical records including documentation of all services provided to the member as well as any specialty or referral services.
- Comply with Community Health Plan Provider Administrative Policies and Procedures.
- Comply with Quality Improvement and Utilization Management Policies and Procedures.
- Utilize participating laboratory, radiology, behavioral health, consulting providers, and pharmacy services.
- Notify Community Health Plan when maximum patient capacity has been reached in the provider's panel and closure is requested.
- Notify Community Health Plan whenever a member does not understand how the managed medical care model is intended to function so that the Customer Service Department may provide education.
- Participate in Community Health Plan activities and/or committees, including but not limited to, Utilization Management, Finance/Membership, and Provider Relations/Quality Review.

III. PRIMARY CARE ENROLLMENT FREEZE

A Primary Care Provider's practice may expand significantly as a result of Community Health Plan member enrollment. If this occurs and the Primary Care Provider has at least 50 Community Health Plan members and is unable to absorb new Community Health Plan members or any new patients, an enrollment freeze may be requested.

To request an enrollment freeze, the Primary Care Provider must send a letter to their Provider Relations Representative requesting a freeze and explaining why the freeze is needed. Once approved, a Provider Relations Representative will notify our Provider File Maintenance staff for system update and internal communication.

On occasion, a request for an enrollment freeze may come after marketing materials listing a practice as "open" have already been distributed. Community Health Plan will make a good faith effort to direct new enrollees to another provider's practice.

A Primary Care Provider, whose enrollment has been frozen, may request that the freeze be lifted if the Primary Care Provider is able to accept new Community Health Plan members.

IV. CONSULTING/REFERRAL PROVIDER'S ROLE

Primary Care Providers will refer Community Health Plan members to participating consulting providers for any service for which specialty care is medically necessary. The provider directory is provided for your convenience. The provider directory contains all specialty providers and ancillary providers. However, a provider's name in the referral directory does not guarantee their participation in Community Health Plan's network. Please reference our online provider directory at www.mychp.com or call our Customer Service Department if you are unsure of a referral provider's status.

Only consulting services that have been referred by the Primary Care Provider will be paid by Community Health Plan. A woman may self-refer to a participating OB/GYN physician once a calendar year for a well-woman exam and anytime for gynecological care. Members who have a vision rider may self-refer to a participating VSP optometrist as specified in the appropriate rider. Members who have chiropractic benefits may access chiropractic services up to the benefit maximum without a referral by the Primary Care Provider. Members diagnosed with diabetes may access an in network ophthalmologist for an annual dilated retinal exam.

The specialist must furnish the PCP a written report of the findings of the consultation and a treatment plan. A Coordination of Care form to use for this purpose is available in the Providers section of www.mychp.com.

Point of Service, Community Choice, Gold Plus, and Kansas POS-2 members may self refer to a provider based on their benefit plan.

V. CONSULTING/REFERRAL PROVIDER RESPONSIBILITIES

- Provide specialty services upon referral by Primary Care Provider.
- Examine and treat the member as requested by the Primary Care Provider and document recommendations and treatment.
- Provide a written report to the Primary Care Provider of the findings of the consultation and the treatment plan. A Coordination of Care form to use for this purpose is available in the Providers section of www.mychp.com.
- Comply with Provider Administrative Policies and Procedures.
- Comply with Quality Improvement and Utilization Management policies and procedures.
- Utilize participating laboratory, radiology, behavioral health and pharmacy services.
- Obtain prior authorization from Community Health Plan for all items that are listed on the Prior-Authorization List.
- Submit completed claims to Community Health Plan per contract.
- Collect specified payments from members.

VI. PROVIDER PRACTICE CHANGES

All participating providers must be credentialed and approved according to the Community Health Plan Minimum Standards and Selection Criteria in order to treat Community Health Plan members. Should you add a new associate to your practice, please notify the Credentialing Department immediately. A credentialing application form is located under the provider button on the website at www.mychp.com. Services can be rendered by this provider once approved as a participating provider and added to the Community Health Plan Provider Directory.

If you or an associate leaves your practice, have a hospital affiliation change, or if you are planning to move your office or open a new location, you must notify the Credentialing Department in writing sixty (60) days prior to any change. By providing this information, you will ensure that your practice is properly listed in the Community Health Plan Provider Directory and that all payments made to you or your associate(s) are available for your review and are properly reported to the IRS. Community Health Plan members are notified and may request another Primary Care Provider, if they so desire, as a result of the change.

VII. COMPENSATION GUIDELINES

Community Health Plan will compensate the provider for covered services the lesser of provider's billed charges or the Community Health Plan Maximum Fee Schedule in effect as of the date of services minus the member copayment, coinsurance or deductibles if applicable.

Compensation for services is based on member eligibility on the date of service (DOS) where services are performed and contingent on member eligibility. Eligibility may be determined retroactively by employer groups.

VIII. RBRVS FEE SCHEDULE

Community Health Plan utilizes a Resource Based Relative Value Scale (RBRVS) fee schedule. The conversion factors are a part of the provider contracts. If you have any questions about any of the fees, please contact your Provider Relations Representative at (816) 271-1247 or (800) 990-9247.

IX. TIME LIMIT FOR SUBMISSION OF BILLINGS

CHP is Primary	Participating Provider	Non-Participating Provider
	Per contract days from DOS	12 months from DOS

CHP is Secondary	Secondary to Commercial Payors	Secondary to Medicare
	12 months from Date of Determination	18 months from Date of Determination

CHP is secondary when corrected claim is submitted	Secondary to Commercial Payors	Secondary to Medicare
	120 days from payment of Primary Payor	12 months from payment of Primary Payor

Inquiries for claims initially filed within the applicable contract provision, ex: four (4), twelve (12), or eighteen (18) month timeframe, will be researched and resolved following existing Plan processes as long as the inquiry is made within twelve (12) months from the determination date.

Note: DOS on inpatient and facility outpatient claims are defined as the “from date” (date of admission). DOS for professional claims is defined as the date of visit.

Proof of timely filing will not be accepted for any claim, regardless of how it is submitted, on paper or electronically. Due to the fact Community Health Plan acknowledges every claim submitted and has educated providers on the applicable reports verifying claim status, the Plan will not accept proof of timely filing as cause to waive the timely filing criteria outlined above.

Please be advised that there are no appeal rights when a claim is denied for not being submitted within the time required per your contract with Community Health Plan.

X. PROVIDER ACCESS STANDARDS

To ensure that members obtain appropriate access to health care and services, Community Health Plan has established the following provider access standards:

Access Standard Description	Standard
Provider Relations – Primary Care Provider	
Preventive Care Appointments (Physical Exam)	Within 4 weeks
Urgent Care Visit	Within 24 hours
Emergency care visit	Available twenty-four (24) hours per day, seven (7) days per week.
Routine office visit (non-symptomatic)	Within 30 days
Routine office visit (symptomatic)	Within 5 days from the time the member contacts the provider
Provision of after hour's services.	Sufficient to maintain 24 hours/day, 7 days per week coverage
Provider Relations – Specialty Provider	
Emergency care visit	Available twenty-four (24) hours per day, seven (7) days per week.
Urgent Care Visit	Within 24 hours
Routine visit (non-symptomatic)	Within 30 days of referral
Routine office visit (symptomatic)	Within 5 days from the time the member contacts the provider
Provision of after hour's services.	Sufficient to maintain 24 hours/day, 7 days per week coverage
Provider Relations – Maternity Care	
OB Access	<ul style="list-style-type: none"> • 1st & 2nd Trimester – 1 week • 3rd Trimester – 3 days
Provision of after hour's services.	Access to an obstetrician 24 hours/day, 7 days per week coverage
Provider Relations – Behavioral Health Provider	
Emergency care visit Life Threatening	Immediately call 911
Non-life threatening	Within 4 hours
Urgent Care	Within 24 hours
Routine Office Visit	Within 10 business days

Access Standard Description	Standard
Provision of after hour's services.	Telephone access to a licensed therapist available twenty-four (24) hours per day, seven (7) days per week.
Provider Relations - Other	
Hours of operation	<ul style="list-style-type: none"> • 20 regularly scheduled hours per week for a one-physician practice. • 30 regularly scheduled hours per week for a two or more physician practice.
Telephone on-hold time during office hours (waiting to speak to receptionist)	< 5 minutes
Response time to urgent telephone call from member.	Within 30 minutes after notification.
Waiting time in office	Reasonable for schedule appointment (i.e., 15 minutes).
Appointments scheduled or conducted per hour	<ul style="list-style-type: none"> • Five visits/hour IM. • Six visits/hour FP, GP & PED
Medical Director	
Waiting time for receiving referral or approval/denial of requested referral by the PCP.	Within 48 hours on business days after complete request
Providers/Practitioners must make the medical records available to The Plan	Within time frame requested by The Plan based upon situation

XI. PROVIDER APPEALS PROCESS

Community Health Plan providers reserve the right to resolve claim issues at an inquiry level rather than an appeal level. All inquiries related to claim denials, claim payment processes, or requests to have a claim adjusted, must be received within one year from determination date or date paid shown on the Provider Remittance Advice. Providers may request claim adjustments in writing by resubmitting the claim, reason for adjustment and attach any supporting documentation. If assistance is needed, call Customer Service or your Provider Relations Representative.

The appeals process is offered to members, a member's designated representative, and providers if they have financial recourse against the member, to resolve adverse benefit determination issues in a thorough, timely and consistent process.

The first level appeal process is offered to provide an opportunity to contest an adverse benefit decision made by Community Health Plan. The first level appeal is reviewed by the Internal Review Committee, which is comprised of Community Health Plan Leadership. If the appeal is for a self-insured member the Quality Review Specialist will forward the documentation to the employer.

Community Health Plan must receive the appeal request in writing and within 180 days from the date of the notification of the adverse benefit determination.

Adverse benefit determination – a determination by Community Health Plan based upon review of one of the following:

- Experimental or investigational
- Determination of eligibility to participate with the Plan
- Admission
- Availability of care
- Concurrent stay review
- Utilization review
- Pre-Existing Condition

And based upon the information provided, it does not meet Community Health Plan requirements for medical necessity, health care setting, level of service or effectiveness and the payment for the requested benefit is therefore denied, reduced or terminated.

A formal written appeal request is made to Community Health Plan address below:

Community Health Plan
Attn: Quality Review Specialist
137 North Belt Highway
St. Joseph, Missouri 64506

Depending upon the appeal type (expedited, pre-service, post-service or Department of Insurance) will determine the allowed time frame to make a determination.

Expedited Appeal – An expedited appeal review process will be followed if the member's life, health or ability to retain maximum function will be jeopardized by utilizing the standard time frame for the appeal process. For an expedited appeal, the review process and determination are made within 72 hours of receipt. A verbal or written request may be used to initiate an expedited appeal. In the case of an expedited appeal, a health care practitioner with knowledge of the member's condition (a health care practitioner treating the member) may act as the member's authorized representative.

Pre Service-Appeal – A written request for reconsideration of an adverse benefit determination that the Plan must approve, in whole or in part, in advance of the member obtaining care or services.

Post-Service Appeal – A written request for reconsideration of a previous adverse benefit determination made by the Plan pertaining to the contractual relationship between the member and the Plan, that the Plan must approve, in whole or in part, for services that have already been received by the member.

Missouri Department of Insurance – Determination must be made within 20 calendar days from the postmark date of the Department of Insurance letter.

Kansas Department of Insurance - Determination must be made within 15 working days from the postmark date of the Department of Insurance letter.

Written notification of the first level appeal resolution and rights for a second level appeal, when available per circumstances, will follow the completed investigation.