

PROVIDER'S RESPONSIBILITIES AND COMPENSATION

Section II

I. PARTICIPATING PROVIDER RESPONSIBILITIES

- Obtain prior authorization from Community Health Plan before performing items listed on the Prior-Authorization List.
- Utilization of participating providers for member services. A participating provider directory can be found on the www.mychp.com website.
- Collect specified payments from members.
- Maintain current member medical records including documentation of all services provided to the member as well as any specialty services.
- Comply with Community Health Plan Provider Administrative Policies and Procedures.
- Comply with Quality Improvement and Utilization Management Policies and Procedures.
- Notify Community Health Plan whenever a member does not understand how the 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.
- Submit completed claims to Community Health Plan per terms of your contract.

II. 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, or if you are planning to move your office or open a new location, or change hospital affiliations, 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.

III. COMPENSATION GUIDELINES

Community Health Plan will compensate the participating 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.

IV. 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.

V. 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 (DOS)	18 months from Date of Determination (DOS)

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.

VI. 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

Access Standard Description	Standard
Routine Office Visit	Within 10 business days
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 24 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

VII. 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 the 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 conditions

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.