COMMUNITY Health Options®

Powered by Purpose

Provider Manual

The Provider Manual, which may be amended from time to time, is incorporated by reference to your Agreement with Community Health Options. It is meant to supplement your Agreement, not to replace it, and wherever the two may differ, the Agreement is controlling. This manual is designed for use by all providers, who in accordance with the terms and conditions set forth in their respective Agreements, provide covered services or supplies to members. Policies and procedures not included in this manual may be posted on the Community Health Options website. healthoptions.org

Table of Contents

About Us

Introduction to Community Health Options

Founded in 2011 and located in New Gloucester, Maine, Community Health Options, is a health insurance pioneer that has your back. We are a local, nonprofit Consumer Operated and Oriented Plan (CO-OP) that puts Members first, working to improve access to care while keeping costs low so Members can actually use their benefits.

We are one of Maine's largest carriers for the individual market and a partner with over 1,200 businesses, a number that continues to grow. Across all plans, we have a robust network of 48,000 providers including clinicians, hospitals, and pharmacies in New England. Most group plans include national coverage, with select plans offering New England only coverage to enhance premium savings.

With a year-over-year renewal rate of more than 90% among our large employer group business, and 86% of brokers scoring Community Health Options an eight or higher out of 10 for willingness to recommend to colleagues (Broker Satisfaction Survey), we are proud of the positive difference we are making in the healthcare marketplace.

Our Mission

To partner locally with Members, businesses, and health professionals to provide affordable, high-quality benefits that promote health and wellbeing.

Our Values

Community Health Options believes:

- Everyone is entitled to courtesy and respect.
- A trustworthy organization demonstrates honesty, integrity, independence and consistency in policy and action.
- Discipline, focus, courage, and humility enable us to be open to learning from the challenges that confront us.
- It is important to embrace change and see positive potential in disruptive innovation.
- Spontaneity, balance, thoughtfulness, and curiosity are essential.

Our Vision

To be a leader in transforming and improving individual and community health and positively affecting local economies.

Commitments

Providers

Community Health Options is committed to collaboration and innovation with providers to improve Members' health, quality of care, and satisfaction while controlling medical costs. Our commitments to you:

- We support you in your role as healthcare provider and coordinator of care with the goal of achieving the triple aim, and to share data that helps you to achieve quality outcomes.
- We provide you with ongoing education and information about our insurance products.
- We collaborate with you to develop innovative models of care that improve the health status of our Members.
- We operate efficiently and effectively to serve you and our Members.
- We welcome your ideas for improvement and actively seek your input through multidisciplinary representation on the Quality Assurance Committee.
- We incorporate value-based insurance design principles that promote evidence-based care, focus on preventive care, and encourage shared decision-making with your patients.
- We honor your right to talk with your patients about appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage.

Value-Based Insurance Design

Community Health Options is committed to the principle of value-based insurance design ("V-BID"). This philosophy promotes the value of care over the volume of care. In operationalizing V-BID, we have developed transparent, accessible processes for both providers and Members. We partner with existing resources such as local care managers, community care teams and others to leverage quality care at reduced costs to the Member and pair clinical information with data for quality and actionable reporting. We strive to create a network design where there are opportunities for shared savings and shared risk. In focusing plan structure on essential health benefits, we are empowering Members and providers to work as a team and truly get the best value with Community Health Options.

Key Contacts

Quick Reference Guide for Providers

General Member and Provider Service Line:
(855) 624-6463

Provider Resources

- **Visit Availity (www.availity.com)** for online authorizations, claims lookup, eligibility & benefits, and more.
- **Visit Community Health Options (www.healthoptions.org/providers/overview)** to access various tools/resources and to sign up for your policy update quarterly bulletin.

Claims Submissions

- **ELECTRONIC:**
  Availity, via your clearinghouse
  Payer ID: 45341
- **PAPER:**
  P.O. Box 1121
  Mail Stop 200
  Lewiston, ME 04243
- **ERA/EFT:**
  Instamed www.instamed.com/eraeft
  Phone: 866-945-7990
- **APPEALS/RECONSIDERATIONS:**
  appeals@healthoptions.org

Provider Support Information

- **PROVIDER RELATIONS:**
  provider@healthoptions.org
- **CONTRACTING DEPARTMENT:**
  (207) 402-3885
  Medical Providers:
  contracting@healthoptions.org
  Behavioral Health Providers:
  bhnetwork@healthoptions.org
- **DATA INTEGRITY:** For In-network Practitioner/Practice Location Adds, Changes, Terms
  Email: dataintegrity@healtoptions.org
  Fax: (207) 520-6742
- **CREDENTIALING:** (Status Inquiries/Questions)
  credentialing@healthoptions.org
- **FIRST HEALTH NETWORK:**
  (800) 226-5116
- **MEDICAL MANAGEMENT**
  Fax: (877) 314-5693
- **PHARMACY:**
  Express Scripts: (800) 417-8164
  Accredo: Specialty Medication (877) 222-7336
  Formulary: www.healthoptions.org/formulary

COMMUNITY Health Options

Legal / Security

Compliance Program

Community Health Options' Compliance Program is designed to oversee the development, implementation and maintenance of compliance and privacy policies that meets federal and state laws and regulations, as well as contractual and accreditation obligations. We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing whenever it may occur in the administration of any of our plans. This commitment encompasses our organization and any of the parties that we contract with to provide services related to the administration of our plans.

HIPAA Compliance / Protected Health Information

Provider and Community Health Options shall comply with, and provider shall cause its facilities, practitioners, and business associates to comply with, the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder at 45 C.F.R Parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), and all other laws regarding confidentiality and disclosure of medical records and other individually identifiable health information, including safeguarding the privacy and confidentiality of any protected health information (PHI).

In the unfortunate event of misdirected PHI, providers are required to notify Community Health Options and immediately destroy documents containing PHI.

Providers

Roles & Responsibilities of Providers

The Agreement between Community Health Options and each provider contains terms and conditions relative to our operations, as well as those required by the Maine Bureau of Insurance and other governmental agencies. Please note that if there is any discrepancy between this manual and the Agreement, the Agreement is the controlling document.

Definitions

Primary Care Provider: ("PCP"), A provider who, within the scope of the provider's practice:

- Supervises, coordinates, prescribes, or otherwise provides healthcare services to a Member and initiates coordination of specialty care;
- Maintains continuity of care; and
- Is so designated by Community Health Options.

Specialist: A healthcare provider who has additional postgraduate or specialized training, board certification, or practices in a licensed specialized area of healthcare.

Network: The providers and organizations who are credentialed by Community Health Options (or a delegated entity) and have entered into a written agreement to provide covered services to Community Health Options Members.

Network PCPs & Specialists agree as follows

Provision of Covered Services: Provider shall provide covered services to covered persons in compliance with the terms and conditions set forth in the Health Options provider Agreement and the provider guidelines.

Standards: Provider shall provide all covered services in accordance with all generally accepted clinical, legal, and ethical standards governing such care, in a manner consistent with provider's license, accreditation, qualifications, training, and experience and/or those of provider's facilities or practitioners, and within the standards of practice for the quality of care generally recognized within the state of Maine and in accordance with the provisions of Health Options Quality Assurance program.

Please refer to your Community Health Options Agreement for specific expectations regarding licensure and accreditation, notices/citations, credentialing, general data and information requirements, determination of covered person eligibility; prior authorization, and admitting privileges, among other pertinent information.

Audit

Please reference the Community Health Options Agreement.

Advance Directives

The provider agrees to comply with the Patient Self-Determination Act (Omnibus Budget Reconciliation Act of 1990) and state regulations and requirements relating to advance directives as such regulations and requirements are applicable to the provider. The Provider shall document in a prominent place in the Member's current medical record whether the Member has executed an advance directive.

Compliance With Complaint and Appeal Procedures

Provider agrees to adhere and cooperate with complaint and appeal procedures in connection with a Community Health Options complaint and/or appeals processes

including, but not limited to, state and federal law, Medicare laws, regulations and the Centers for Medicare and Medicaid Services (CMS) instructions and Community Health Options procedures.

Provider Locations

The provider shall provide healthcare services at the location(s) approved by Community Health Options. Provider shall notify Community Health Options of any additional location(s) where provider provides healthcare services to Members prior to rendering those services to Members at such location(s). Community Health Options reserves the right to approve additional provider location(s) based on, but not limited to, provider's compliance with the terms and conditions of the Agreement, Health Options' development of appropriate geographic provider coverage, as applicable, and Health Options business need. Please reference the Provider Directory section.

Hospitalization

For hospital covered services, PCP and/or specialist will admit Members to a provider, if possible. PCP and/or specialist may refer a Member to a non-participating provider for covered services as may be medically necessary and upon the prior approval of Health Options, unless otherwise permitted in accordance with the terms and conditions of coverage set forth in the Member's Benefit Agreement.

Missed Appointments by Members

In the event a Member fails to present for a scheduled appointment, the provider may collect from the Member the amount owed for a missed appointment charge pursuant to the provider's current policy, which shall not be discriminatory to our Members.

Community Health Options will not be responsible to reimburse the provider for missed appointment charges.

Advertising Guidelines

Use of Community Health Options' name and likeness is permitted only with prior written approval. We limit and control how, when and in what context the name, logo, likeness, and representations are employed in any advertising.

Risk Adjustments

Risk Adjustment Program - Purpose & Administration

The purpose of the commercial Risk Adjustment program administered by Health and Human Services ("HHS") under the Affordable Care Act ("ACA") is to lessen or eliminate the influence of risk selection on the premiums that issuers charge and the incentive for issuers to avoid sicker enrollees. The HHS Risk Adjustment methodology is designed to compensate issuers for differences in enrollee health mix so that plan premiums reflect differences in scope of coverage and other plan factors, but not differences in health status. This compensation is in the form of transfer payments between all ACA issuers in the individual and small group markets (or merged market, as applicable) in the state. Transfer payments are made from issuers with enrollees with healthier risk profiles to issuers with enrollees with less healthy risk profiles.

Enrollee risk profiles are derived from demographic (age and gender) and health status factors defined by HHS on an annual basis. Enrollee demographic data and diagnosis codes are reported to HHS via submission to the External Data Gathering Environment ("EDGE") on an annual basis. Thus, all enrollee data must be recaptured each year.

Patient Encounter

Successful execution of the Risk Adjustment program and provision of high-quality healthcare begins with the patient encounter. Providers should actively outreach to patients to schedule annual wellness visits, as well as ongoing management of chronic conditions. Community Health Options partners with Inovalon to close gaps in care and improve clinical outcomes through Member outreach, encounter facilitation and in-home and virtual health visits. We encourage providers to adopt Inovalon's Converged Patient Assessment solution to facilitate in their treatment and documentation of the patient's encounter. For more information on Inovalon's Converged Patient Assessment solution, please contact Provider Relations at 207-402-3347 or Provider@healthoptions.org.

Encounters should involve assessment, evaluation, treatment, plan and/or referral of current health status and chronic conditions. A review of current medications should be conducted in relation to active medical conditions, and medication lists should indicate the medical condition for which it is prescribed. Lifelong permanent conditions (e.g., down syndrome, quadriplegia, etc.) must be assessed and documented annually.

Each patient encounter should be fully documented, and the associated claim must accurately reflect the procedures performed and all active diagnoses.

Medical Record Documentation Requirements

Maintaining proper documentation of patient encounters, diagnoses and chronic conditions helps Community Health Options fulfill its obligations under the Affordable Care Act. HHS requires physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding guidance published in ICD-10-CM and ICD-10-PCS classification, ICD-10-CM Official Guidelines for Coding and Reporting, AHA Coding Clinic, current year Risk Adjustment Validation Audit Protocols and provider or facility developed coding guidelines. In all cases, the medical record documentation must support the ICD-10 codes or successor codes selected and demonstrate proper use of coding guidelines by the provider or facility. For example, in accordance with the guidelines, it is important providers and facilities code all conditions that co-exist at the time of an encounter that require or affect patient care, treatment or management. In addition, coding guidelines require that the provider or facility code to the highest level of specificity which includes fully documenting the patient's diagnosis.

HHS medical record documentation requires:

- Patient's name and date of birth appear on all pages of record.
- Patient's condition(s) be clearly documented in record.
- Date of service/encounter appear on the record. The dates of service and/or discharge date must fall within the benefit year.
- An acceptable provider type, source, and provider specialty.
- Permissible documents for abstraction. Diagnostic reports, provider orders and list of medications cannot substantiate a diagnosis alone and must be reviewed and documented with a valid medical record and progress note from the interpreting Provider.
- Demonstration that the condition was monitored, evaluated, assessed, addressed, or treated "(MEAT"), or evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral ("TAMPER").
- Descriptions of the condition and MEAT or TAMPER must be legible.
- Information must be complete, clear, and concise.
- Currently active conditions and previously treated and resolved conditions must be accurately noted and coded as such. Coding guidelines permit coding of suspected conditions for Inpatient encounters only. For outpatient and professional encounters, code only the signs and symptoms of suspected and not yet confirmed conditions.
- The use of standard and appropriate abbreviations. Use the abbreviation that is appropriate for the context in which it is being used.
- The Physician's/Qualified Non-Physician's signature, credentials and date must appear on the record and must be legible. Examples of acceptable electronic signatures

include, but are not limited to, “Electronically signed by,” “Accepted by,” and “Authenticated by.”

Medical records are a valuable source of diagnosis data. Under the HHS risk adjustment program, Community Health Options is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician (e.g., nurse practitioner) encounters.

As a condition of the facility or provider’s Agreement with Health Options, the provider or facility shall comply with Community Health Options’ requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or Risk Adjustment data in a timely manner to Health Options, or designee, upon request.

RADV Audit

In accordance with HHS Risk Adjustment guidelines, the Centers for Medicare & Medicaid Services (“CMS”) will perform a Risk Adjustment Data Validation (“RADV”) audit to validate the Patient Enrollees’ diagnosis data which was previously submitted to EDGE by the issuers. These audits are conducted for each benefit year. Medical records are used to validate this diagnosis data, and providers or facilities that treated the patient enrollees included in the audit will be required to submit medical records to Community Health Options for coding review. Providers should be contacted between June and November to submit medical records for the previous calendar year of member sample claims under review.

Compliance with Federal & State Laws, Audits & Record Retention Requirements

In compliance with The HIPAA Privacy and Security Rules, medical records and other health and enrollment information of patients must be managed under established procedures which:

- Safeguard the privacy of any information that identifies a particular patient;
- Maintain records and information in a manner that is accurate and timely; and
- Identify when and to whom patient information may be disclosed.

In addition to the obligations of The HIPAA Privacy and Security Rules, Community Health Options and its providers and facilities are obligated to abide by all federal regulations and state laws regarding confidentiality and disclosure of medical health records, including mental health records, and enrollee information.

Community Health Options and its providers and facilities must maintain documents and records, whether paper, electronic, or in other media, sufficient to enable the evaluation of our compliance with applicable Risk Adjustment standards, including RADV, for each benefit year for at least ten (10) years, and must make those documents and records available upon request to CMS, the Office of Inspector General (OIG), the Comptroller General, or their designees for purposes of verification, investigation, audit, or other review.

Credentialing & Terminations

Credentialing

Credentialing is a systematic approach to the collection and verification of an applicant's qualifications and their ability to meet Community Health Options criteria. Each healthcare provider must, at the time of application for initial empanelment with Community Health Options and through his/her empanelment with Health Options, satisfy the credentialing criteria set for in this document. Credentialing is required for a provider to obtain reimbursement on claims.

Community Health Options requires the following provider types to be credentialed by Health Options prior to providing covered services to Members:

Medical Doctor (MD)	Doctor of Osteopathic Medicine (DO)
Advanced Practice Nurse Practitioners (APRN) (NP) After the 2-year supervisory period is over and they must be *licensed to practice independently*	Locum Tenens Providers – *if providing more than 90 days of coverage.*
Oral & Maxillofacial Surgery DMD	Dentist (DDS)
Certified Registered Nurse Midwives (CNM or NMW)	Podiatrist (DPM)
Chiropractors (DC)	Ophthalmologists (MD)
Optometrists (OD)	Naturopaths (ND)
Physical Therapists (PT)	Occupational Therapists (OT)
Speech Therapists (SLP)	Dietician (DT)
Audiologists (AUD)	Applied Behavioral Analysts (ABA)
Licensed Alcohol & Drug Counselor (LADC)	Licensed Marriage and Family Therapist (LMFT)
Licensed Clinical Professional Counselor (LCPC)	Psychiatric Mental Health Nurse Practitioner (PMHNP)
Licensed Clinical Mental Health Counselor (LCMHC)	Licensed Clinical Social Worker (LCSW)

Doctor of Philosophy (PhD)	Federally Qualified Health Center (FQHC) Behavioral Health Providers
Physician Assistants (not under supervision; see Physician-Assistant Services Policy)	Acupuncturists

All providers must complete the credentialing application and provide all requested information necessary to evaluate the application. Unless and until Community Health Options receives complete and accurate information as requested in the application, including information regarding the provider credentialing criteria and any other criteria set forth in the Credentialing Policy, an application will be deemed incomplete. If the application remains incomplete for a period of 15 days, the applicant will be deemed to have voluntarily withdrawn the request for empanelment and the credentialing process will be discontinued.

Information to confirm or submit include:

- Current physical or mental health problems that interfere with provider's ability to care for Health Options Members;
- Proof of current competence and demonstrated ability (minimum of two in the past three years recent and continual experience) to provide clinical care in each of provider's specialty(ies) according to the contracted scope of practice. If the provider does not meet this experience requirement, a detailed timeline of professional activities and/or specific reason(s) for a non-activity is to be provided as part of the application, which will be considered by the Credentialing Committee on a case-by-case basis;
- No experience of prior Community Health Options denial/involuntary termination; and
- Demonstration of appropriate quality and utilization patterns after review of data obtained from hospitals, managed care organizations, Medicare, insurance entities, professional liability carriers, and the National Practitioner Data Bank. (This information will be obtained, and the primary source verified during the credentialing process).

All Physicians must show proof of:

- M.D., D.O. or D.P.M. degree from an accredited medical school;
- Current, unrestricted license(s) to practice medicine or osteopathy;
- Current Drug Enforcement Agency (DEA) certificate (except radiologists and pathologists);

- Current certificate of insurance indicating professional liability insurance coverage as agreed to in accordance with the executed contract between the provider and Community Health Options;
- For M.D.s and D.O.s, Community Health Options requires board certification or proof of board qualification/eligibility in the orderly process of obtaining board certification by a board accredited by the American Board of Medical Specialties or the American Osteopathic Association

Exceptions to this criterion may be applicable:

- A physician who has not yet practiced for a sufficient length of time to complete board certification. Board certification must be obtained no later than five (5) years from initial credentialing. The Credentialing Committee, upon recommendation by the Chief Medical Officer (CMO), may waive the requirement for specialty Board Certification if the specialty is underserved and/or the Provider's training and experience meet the qualifications of certification and current practice is of high quality as attested by peer references.
- A rural (non-Metropolitan Statistical Area (MSA)) physician must have greater than five (5) years of experience in the specialty in which they practice and have completed an approved applicable residency or fellowship in the specialty of practice.

Community Health Options, at its discretion, will investigate and request further documentation from providers when any of the following professional liability claims situations exist:

- Allegations of sexual misconduct;
- Non-surgical physicians or other healthcare providers with two or more claims in a biennium and any surgical physician with four or more claims in a biennium; or
- Intentional harm or intentional abuse.

To qualify as a Primary Care Provider (PCP), providers must:

- Be a licensed M.D or D.O.
- Practice as a PCP at least 50% of the time in which the provider engages in the practice of medicine.

In certain circumstances and based on the Provider Agreement, a certified nurse practitioner (NP) or physician's assistant (PA) may be designated as a PCP when the state regulations do not prohibit or set limitations on their scope of responsibility.

Network providers shall maintain appropriate clinical privileges, including admitting privileges if applicable, in good standing at an inpatient hospital facility that is a network provider or that is affiliated with a network provider.

Other Licensed Providers are required to show proof of:

- Post-secondary education degree and, if applicable, post-graduate training appropriate to the specialty care provided to Members;
- Current, unrestricted license(s) to practice the provider's specialty(ies);
- Current Drug Enforcement Agency (DEA) certificate, if applicable; and
- Current certificate of insurance indicating professional liability/malpractice insurance coverage as agreed to in accordance with the executed Agreement between the provider and Health Options.

Non-Credentialed Providers

Providers who do not require credentialing (Providers that Members cannot choose):

Anesthesiologists (UNLESS they provide Pain Management Services, then credentialing is required.)	Certified Registered Nurse Anesthesiologists (CRNA) UNLESS they provide Pain Management Services, then credentialing is required.)
Hospitalists	Radiologists
Pathologists	Emergency Medicine
Neonatologists	Providers at Skilled Nursing Facilities – they bill under the facility
Locum Tenens providing less than 90 days of coverage	

Providers not eligible to become in-network providers:

Certified Professional Midwives (CPM) Not eligible to be in network. Not to be confused with Certified REGISTERED Nurse Midwives (CNM) who are eligible.	Registered Nurse First Assists (RNFA) Supervised and bill under supervising provider
Physician Assistants (under supervision and in an inpatient setting; Physician-Assistant Services Policy)	Supervised Nurse Practitioners (APRN) (NP) – Per State licensure, they are supervised the first 2 years and must bill under supervising provider.

Applicants approved as providers by the Community Health Options Credentialing Committee will receive notification that indicates their effective date. Recredentialing of providers occurs at least every three years and includes verification of new

education/training; verification of licensure and board certification; and a review of relevant quality indicators such as Member concerns/complaints, as applicable. Additionally, applicable DEA/CDS Certificate, Maine Excluded Providers Life, current hospital affiliation and sanctions for providers are also checked for recertification.

Applicants/providers have the right to be informed of the status of their application and to review the information received by Community Health Options from outside primary sources obtained during the credentialing/recredentialing process unless laws prohibit disclosure of such information. Additionally, applicant providers will receive written notification when information that is critical to the credentialing/recredentialing process varies from the information supplied by the applicant provider. We will allow applicant providers 15 days to respond to and/or correct such information.

Locum Tenens

Locum tenens is a covering provider temporarily taking the place of another provider, usually for a defined period. Community Health Options does not require the credentialing of *locum tenens* who meet the following criteria:

The credentialing policy would apply for *locum tenens* who meet either of the following criteria:

- The *locum tenens* will be providing services in the capacity of locum tenens at the same location for a period exceeding 90 continuous days.
- There is no participating supervising provider identified for claims submission.

For more information on current credentialing standards and criteria, contact the Credentialing Department via Service Center at (855) 624-6463.

Participation Through a Group Agreement

Subject to meeting Community Health Options' credentialing and other criteria, an individual provider may participate with us through a partnership, corporate, or other type of business entity agreement in which such entity is deemed to have signature authority on behalf of the individual provider. If an individual provider discontinues their association with a contracted partnership, corporation, or business entity, then the individual provider will no longer maintain a provider status with us. If the individual provider desires to continue participating in the network as a provider, then the provider must enter into a new agreement directly with Community Health Options. The provider may or may not be subject to recredentialing. We evaluate all requests for participation and reserve the right to approve additional providers based on our business needs.

Provider Directory

Community Health Options Members or providers can view providers and facilities using the online directory available on the HealthOptions.org website. Providers should validate their online profile, a minimum of once every 90 days, to ensure patients have access to the most current information. If updates to a provider's profile are required, please notify our Provider Configuration team at dataintegrity@healthoptions.org. We require 30-day notice of any upcoming changes.

Provider Configuration - Notification of Changes affecting Credentialing Status

Providers are required to notify Community Health Options immediately of any changes that may affect the credentialing status of the provider. Failure of a provider to notify us immediately of any such changes including, but not limited to, licensure action, privileging status, may jeopardize a provider's status and may result in termination from the Community Health Options network.

Community Health Options strives to ensure that our Members have the most up-to-date information for their providers. Provider demographic information is public facing for our Members on our Provider Directory and through various provider portals. In addition, this information is configured in our claims payment system which assists in timely and accurate claims payment. Our credentialing and recredentialing processes help ensure we are compliant with applicable regulatory agencies and NCQA accreditation standards.

As a contracted provider, if you have any of the following updates/changes to your Facility/Practice:

- Name
- Location Address
- Billing Address
- Primary/Fax Telephone Number(s)
- Language
- TIN (Tax Identification Number) Current year W9 must accompany form.
- Location NPI
- Website URL
- Term Location

Please fill out our Practice and Facility Information Form located at our website (must be received 30 days prior to effective date of change): Practice Facility Information Form

As a contracted practitioner, if you have updates/changes to your practitioner profile:

- Name
- Accepting New Patients
- Facility/Practice
- NPI
- Term Provider
- Term Provider from Facility/Practice

Please fill out our Provider Credentialing and Change Form at our website (information must be received 30 days prior to effective date of change): Provider Credentialing Change Form

Both forms can be submitted via e-mail to: dataintegrity@healthoptions.org
All forms submitted must be completed in their entirety. Incomplete forms will be returned and not processed.

Accessibility of Services

Standards for Members Access to Services

Community Health Options set the following standards for Member access to services by its contracted healthcare providers:

PCP AND SPECIALTY PROVIDER ACCESSIBILITY	COMMUNITY EALTH OPTIONS STANDARDS
Emergency Services	Seen immediately by PCP or designee (in office or emergency room, if appropriate) When a patient calls a provider or an organization with an emergency need, the provider or organization is required to immediately contact the patient or direct the patient to the emergency room or 911 in their message if the phone call is not answered immediately.
Urgent Care Services	Appointment with PCP or designee within 96 hours
Routine Care Appointment(s)	PCP: 15 business days Specialty Physician: 30 business days Ancillary Services: 30 business days

Preventive Care Appointment	Must be consistent with professional recognized standards as determined by the provider acting within the scope of his or her practice.
24 Hour Availability	PCPs should be available 24 hours/day, seven days/week.
Non-Business Hours Access (answering service or answering device)	An answering service or device should answer 100% of the time. If used, answering devices will provide the caller with the PCP or designated covering PCP's telephone and/or pager number, including emergency instructions.
Appointment Wait Timer	PCP or designee should see a Member within 30 minutes of scheduled appointment time.

It is the hope that all Community Health Options providers strive to meet the Primary Care Medical Home (PCMH) accessibility standards.

BEHAVIORAL HEALTH PROVIDER ACCESSIBILITY	STANDARDS
Emergency Services	Seen immediately by PCP or designee (in office or emergency room, if appropriate). When a patient calls a provider or an organization with an emergency need, the provider or organization are required to immediately contact the patient or direct the patient to the emergency room or 911 in their message if the phone call is not answered immediately.
Non-life-Threatening Emergency	Within six hours or directed to the emergency room or crisis center
Urgent Care Services	Appointment with PCP or designee within 48 hours
Routine Care Appointment(s)	Initial Routine Appointments: 10 business days Follow-up Care: 30 business days
24 Hour Availability	PCPs should be available 24 hours/day, seven days/week.
Non-Business Hours Access (answering service or answering device)	An answering service or device should answer 100% of the time. Answering devices, if utilized, will provide the caller with the PCP or designated covering PCP's telephone and/or pager number, including emergency instructions.

Appointment Wait Timer	PCP or designee should see a Member within 30 minutes of scheduled appointment time.

Coverage During PCP/Specialist Absence

A contracted PCP or specialist must arrange for another contracted PCP or specialist, with appropriate training or specialty, to assume responsibility during an absence. Additionally, the coverage arrangement must be with another provider who has admitting privileges at a contracted hospital.

PCP Practice Acceptance Status - Member Panel

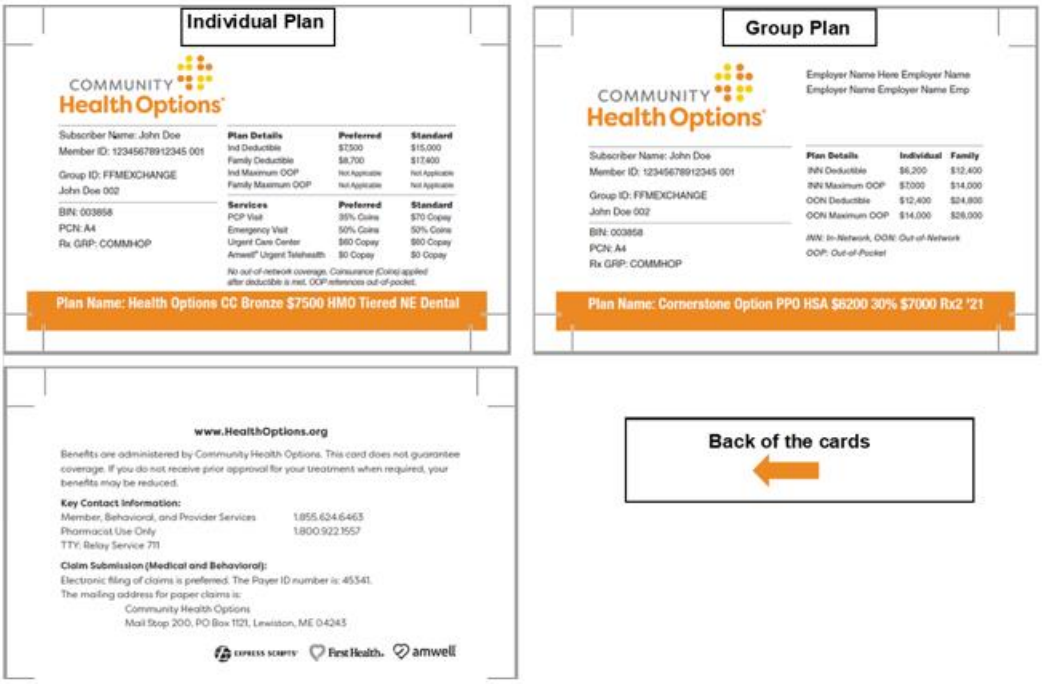
In the event a PCP determines it is necessary to limit their clinical practice to new Community Health Options membership because of the PCP practice membership capacity, the following conditions are required:

- Advanced written notification of a minimum of 30 business days before the effective date of the limitation.
- PCP acknowledges they will continue to accept all current Community Health Options membership and will continue to provide medical services to assigned Member(s), regardless of a pre-existing provider-patient relationship.
- PCP acknowledges that changing to “accepting existing patient” status represents that they will continue to accept all patients who may change to Community Health Options coverage and the change will not be published in written Member and/or provider material until next applicable printing, and
- PCP must concurrently establish a limited membership acceptance status with all other managed care plans with which PCP participates.

Members

Member Identification Cards (2024)

Members will be expected to present their ID card when receiving services from plan providers.



Member Rights & Responsibilities

We regard our relationship with Members as a vital partnership and want to play a role in improving Member health and wellbeing. Understanding Member Rights and Responsibilities will help Members to get the most out of the plan and be a healthier self.

Please see full Member Rights & Responsibilities

Utilization Management Program

Utilization Management Guidelines & Medical Policies

The Utilization Management (UM) Department encourages and facilitates the use of the most appropriate medically necessary level of care to Members. The UM department utilizes nationally recognized guidelines as well as internal medical benefit policies and other resources to guide decision making in care reviews in accordance with the Member's applicable benefit document and eligibility. Community Health Options modifies third-party UM guidelines, when applicable, to address nuances of the local care delivery system and/or create our medical policies for new services, procedures, and new applications of existing services and/or procedures where evidence-based guidelines have not been well established.

Community Health Options may partner with UM vendors who adhere to our required standards.

UM guidelines and medical policies are not intended to be a substitute for provider judgement. UM senior leadership reviews medical necessity authorization requests when submitted clinical information does not support substantiate medical necessity criteria is met. The UM senior leader reviews submitted clinical information and makes an authorization determination, considering the local care delivery system and the unique circumstances of each case.

Authorizations: Prior Approval (PA) & Notification Requirements

Community Health Options posts Prior Approval & Notification requirements on our website at healthoptions.org and on our provider portal at https://provider.healthoptions.org. Prior Approval & Notification requirements are subject to change. Providers are required to rely on current online resources regarding authorization requirements on the date of service. While changes to authorization requirements occur periodically changed without notice (e.g., updated CPT/HCPCS codes), we provide a 60-day notice on our website and provider portal of any substantive authorization requirement changes (e.g., timeliness filing, new category of services that requires authorizations, etc.). Annual updates are posted in the Provider Bulletin by Nov. 1. It is the provider's responsibility to review and adopt updated PA forms by Jan. 1 each year. Periodic updates are made throughout the year. Notation of last update is documented on each authorization guide/form.

Resource: Notification & Prior Approval Guide

Authorization Submissions

Authorization submissions are limited to providers who are fully licensed to practice independently for services that are within their scope of practice. A designee may submit the request on behalf of an eligible provider, but the request must be submitted under the qualified provider's name as submitting or rendering provider for a servicing provider/organization.

Online Authorizations Quick Guide

Documentation Requirements

1. Completed Community Health Options Notification and Prior Approval form or provider portal submission with supporting clinical documentation.
2. Unless otherwise specified by Community Health Options Medical Management team, daily submission of clinical information to substantiate medical necessity for ongoing inpatient stays.
3. Clinical documentation to support medical necessity 24 hours before anticipation of an extended stay.
4. Discharge planning commences on the day of admission and status updates are provided throughout the stay.
5. Community Health Options Medical Management team provides support for discharge planning and coordination. Timely collaboration with the Medical Management team is required to facilitate efficient and effective transitions of care.

Upon receipt of requested information, the UM department will provide oral and written notification of the determination of coverage. Notification will occur within applicable regulatory or NCQA time frames, whichever is more rigorous. Notification shall include information on the provider's right to appeal any determination of coverage.

Prior Approval Does Not Guarantee Coverage or Payment

A Member's coverage is pursuant to the Member Benefit Agreement. Prior Approval & Notification requirements may vary based on the Member's applicable benefit plan.

It is the provider's responsibility to request prior approval for applicable services. Providers contracted with Community Options shall obtain any/all required prior approvals for covered services in advance of providing covered services to a Member.

A Member is not financially responsible for a provider's failure to (i) obtain Prior Approval or submit timely notification, or (ii) provide required accurate information to Community Health Options.

Member Eligibility

It is the provider's responsibility to check Member eligibility status on the date of service to confirm Member remains eligible for benefits.

Prior Approval requests submitted to Utilization Management are reviewed by the UM team and Member eligibility is determined at the time the request is submitted. If the Member is ineligible, either because of non-effectuation or termination from the plan, the UM team will notify the submitting provider that the Member is not eligible for services and

the Prior Approval is voided. If a Member is in an extended grace period for non-payment of premiums, claims will be denied until the Member pays premiums in full. Claims will be reprocessed upon reinstatement or termination of plan.

Utilization Management Determinations

Community Health Options and delegated Utilization Management partners, when applicable, review prior approval requests and make determinations based on eligibility, benefit coverage and medical necessity review.

Authorization determinations are approved, partially approved, or denied. Approvals indicate medical necessity review criteria is met. The provider is required to verify eligibility on the date of service. Partial approval indicates some requested services are approved and some requested services are denied. Denied indicates all requested services are denied.

Adverse authorization determinations include administrative, benefit, and medical necessity denials.

Administrative denials are issued when timely UM submission requirements are not met.

- Authorization is not submitted within designated timeframes.
- Notification of admission is required within 48 hours (or by noon on the first business day following a weekend or holiday) even if the patient is already discharged
- Notification of an outpatient/ambulatory service within 10 business days of the date of service or pre-service
- Within 10 business days of the date of service for any modification of a CPT/HCPCS code to an approved authorization request
- Authorization request is for a non-covered provider (e.g., out-of-network providers when Member has an HMO plan)
- Authorization request is for a non-covered service (e.g., cosmetic related procedures; experimental/investigational services)
- Inappropriate/unlisted CPT/HCPCS Code: Providers must submit CPT/HCPCS code(s) to the highest specificity, if none are available an unlisted code may be appropriate.

Medical necessity denials are issued when submitted clinical information does not meet evidence-based guideline criteria.

Community Health Options notification of an adverse decision for authorization service requests that require medical necessity review includes notation of the specific clinical policy or guideline used to make the decision and rationale for the adverse decision. The provider can request a copy of the full medical policy or UM guideline that informed the adverse determination by calling the UM department at (877) 314-5693, between 8 a.m. and 5 p.m., Monday-Friday.

Please reference Adverse Utilization Management Decisions Policy.

Financial Incentives

Utilization Management decision-making is only based on Member eligibility, benefit coverage and appropriateness of care and services. We do not specifically reward or provide financial incentives to UM practitioners or individuals for issuing denials.

Submission & Determination Timeframes

Emergency Services

911 emergency ambulance transports and emergency department services) do not require Prior Approval. However, once the medical condition is stabilized, Prior Approval & Notification requirements apply for all services that require notification and prior approval. Treatment received outside the emergency department may require prior approval.

While Prior Approval is not required for emergency department (ED) services, a Member is encouraged to discuss the emergency with their primary care provider (PCP) either prior to, if time permits, or following the ED visit.

Emergent admission to or inpatient status requires notification as soon as possible and notification is required to be within 48 hours of an admission. Notification requires, at a minimum, Member demographic information, CPT/HCPCS code, and primary diagnosis.

Failure to provide timely notification of an admission will result in concurrent review commencing on the day of notification. Lack of timely notification may result in denied claims for the inpatient days prior to notification.

Urgent requests

Include medical care or treatment with respect to which the application of time periods for making non-urgent prior approval decisions could seriously jeopardize the life or health of

the Member or ability of the Member to regain maximum function, or in the opinion of the provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the authorization request.

Urgent/unscheduled admissions require notification to Community Health Options UM team as soon as possible and MUST be within 48 hours of admission. Notification requires, at a minimum, Member demographic information, CPT/HCPCS code, and primary diagnosis.

If 'urgent' is selected inappropriately and it is clear to our UM team that the request is routine, we will change the status to routine and process accordingly routine prior approval/pre-service requests:

A. Member demographics, diagnosis for inpatient admissions.
B. Member demographics, diagnosis, and all applicable CPT/HCPCS procedure codes for ambulatory/outpatient services.

Prior approval of routine requests for elective inpatient procedures does not eliminate the requirement for admission notification to our UM team within 48 hours of admission.

Failure to provide timely notification of an admission will result in concurrent review commencing on the day of notification.

Transplants

If a Member requires a transplant, it is the sole responsibility of the treating provider to obtain Prior Approval. Providers can obtain prior approval for a transplant procedure by contacting the UM department at (855) 624-6463.

Additional health care navigation support for organ transplants is available through Community Health Options' Complex Care Management program. Providers can make referrals to the Care Management team by contacting our Service Center at (855) 624-6463.

If the provider or designee indicates the authorization request is urgent, you are personally attesting that the requested service is urgent based on the Member's clinical presentation, and it is not for Member, provider, or organization convenience.

Inpatient Admissions & Appropriate Level of Care

- Notification of elective scheduled and unscheduled admissions is required within forty-eight (48) hours (or by noon on the first business day following a weekend or holiday) even if the patient is already discharged.
- Concurrent Review Extended Stay Requests: Notification request for an extended stay with additional clinical information is required within twenty-four (24) hours of the authorization expiration date (last covered day). Failure to request additional days within 24 hours may result in denied days.
- Level of Care Change: Notification is required within 24 hours of transition to a higher or lower level of care (LOC) within the same facility. Failure to notify a change in LOC may result in a claim denial when claim LOC does not match the authorized LOC for any given day.
- Inpatient stays: Provider has up to one business day to provide the additional requested clinical information. Failure to provide additional clinical information within one business day of the request may result in denied days.

Newborns staying an extended stay after the Mother has been discharged will require notification and clinical notes 24 hours before the expected discharge date of the Mother.

Community Health Options does not reimburse for claims submitted for an amount higher than the approved level of care (e.g., acute care, skilled nursing, and rehabilitation facilities).

Discharge Planning

Discharge planning commences on day one of admission and includes identification of anticipated support services that are in place or need to be in place on day of discharge to support Member's functional ability and psychosocial needs. Discharge planning considers the Member/family/caregiver/authorized representative's ability and availability to support Member needs upon discharge. Discharge planning also includes coordination of medical services and supplies, clinical personnel, and community resources to facilitate Member's timely discharge to a more appropriate level of care following an inpatient admission.

Avoidable inpatient days that are the result of provider or organization preventable delays may be denied. If the Member's condition meets discharge criteria from the inpatient setting, any preventable delayed days, regardless of reason, is subject to medical necessity review and may not be an approved/covered day.

Once administrative rules, benefit coverage, and prior approval requirements have been verified, the service request is reviewed for medical necessity. A delegated reviewer (physician, PhD behavioral health provider or pharmacist) makes adverse medical necessity

determinations based on submitted clinical information that takes into consideration the individual's unique circumstances and nuances of the local delivery system.

Note: As a business rule, Community Health Options defines medical necessity as services or supplies in accordance with standards of good medical practice, consistent with the diagnosis, and the most appropriate level of care provided in the most appropriate setting, at the most appropriate time. In cases when there is a delay of care (variance day) where we determine the care was not performed in a timely manner, the care day may be denied. Example of a hospital variance: Internal or external department practices, actions and policies that delay expected course of care, such as operational inefficiencies, which are under hospital control, or unavailability of certain services or personnel.

Providers and organizations who anticipate delayed discharge due to transition-of-care barriers are encouraged to request assistance from Community Health Options' UM team.

Retrospective Authorization Requests

Retrospective authorization requests are processed within thirty (30) calendar days of receipt of all necessary information to include, at a minimum:

- Member demographics, diagnosis, admission and discharge notes and any applicable clinical notes for inpatient admissions.
- Member demographics, diagnosis, all applicable CPT/HCPCS procedure codes, and any applicable clinical notes for ambulatory/outpatient services.

Retrospective review considers factors such as Member eligibility, benefit coverage, authorization requirements and the medical necessity of the services at the time the service was provided:

- Must be submitted within 10 business days of the date of service for ambulatory/outpatient procedures.
- Must be submitted within 10 business days of the date of service for any modification to a previously approved service request.

Dialysis Services

Community Health Options provides benefits for kidney dialysis on an inpatient or outpatient basis, or at home. Coverage for dialysis in the home includes nondurable medical supplies, drugs, and equipment.

Experimental, Investigational or Unproven Services

Experimental, investigational or unproven services are any medical, surgical, psychiatric, substance use disorder or other healthcare technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for or not identified in the American Hospital Formulary Service as appropriate use, and are referred to by the treating healthcare provider as being investigational, experimental, research-based or educational;
- The subject of an ongoing clinical trial that meets the definition of a phase I, II, or III clinical trial set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight; or
- The subject of a written research or investigational treatment protocol being used by the treating healthcare provider or by another healthcare provider who is studying the same service.

If the requested service is not represented by criteria listed above, Community Health Options reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support:

- The service has a measurable, reproducible, positive effect on health outcomes as evidenced by well-designed investigations, and has been endorsed by national medical bodies, societies or panels regarding the efficacy and rationale for use;
- The proposed service is at least as effective in improving health outcomes as established treatments or technologies, or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied;
- An improvement in health outcomes is attainable outside of the clinical investigation setting;
- Most healthcare providers practicing in the same medical specialty recognize the service or treatment to be safe and effective in treating the specific medical condition for which it is intended; and
- The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

Community Health Options reserves the right to exercise its own discretion in coverage determinations for experimental, investigational, and/or unproven procedures and treatments. Providers are encouraged to contact the UM department for prior approval. For experimental/investigational or unproven services that do not have an established reimbursement rate, the provider must supply an invoice related to these services.

Electronic/Facsimile Data Exchange

Providers are required to follow federal and state guidelines surrounding electronic or facsimile data exchange, and to use those means for supplying needed clinical status and other data to Community Health Options to inform and support timely utilization management decisions. This includes, but is not limited to, ADT reports (admissions, discharge, and transfer), daily census reports, a patient's confirmed discharge date and other relevant clinical data.

Failure to Comply with UM Program

As provided in the Provider Guidelines, Provider shall cooperate with, participate in, and abide by the decisions of any quality assurance, quality management, utilization management, or utilization review programs established by MCHO or any applicable Plan. Provider acknowledges and agrees that Provider's failure to comply with any such (i) utilization management or utilization review decisions, or (ii) quality assurance or quality management decisions, shall be grounds for sanctions as specified in the Provider Guidelines, including without limitation partial or complete denial of payment for specified Covered Services or termination of Provider's participation in a Plan.

Pharmacy Formulary

Community Health Options uses a drug formulary provided by our Pharmacy Benefit Manager (PBM), Express Scripts, to ensure rational selection and use of medications, and to ensure quality, cost-effective prescribing. The formulary is developed with the input of practicing providers and pharmacists who participate in the Express Scripts® National Pharmacy and Therapeutics (P&T) Committee. Medications in each therapeutic class have been reviewed for efficacy, safety and cost. The PBM, in coordination with Community Health Options, continually reviews new medications as well as information related to medications currently included in the Formulary.

Currently the drug Formulary consists of five tiers:

- Tier 1- Generics, best value
- Tier 2- Generic
- Tier 3- Non-Preferred Generics and Preferred brands
- Tier 4- Non-Preferred brand
- Tier 5- Specialty (specialty- SP and mandatory specialty – MSP)

Our current formulary and supporting documents can be found at https://www.healthoptions.org/formulary

Pharmacy Benefit Management (PBM)

Community Health Options' PBM, Express Scripts, can assist providers with pharmacy-related questions. A list of drugs, known as a formulary, is developed to optimize Member care through the selection and use of drugs, and to ensure quality prescribing practices. Our formulary is a culmination of the Express Scripts Nationally Preferred Formulary and our benefit design.

Medications in each therapeutic class are reviewed with respect to safety, efficacy, currently available agents, and cost-effectiveness for Members. The most appropriate medications are then selected for inclusion in the formulary. Express Scripts continually reviews new medications and information concerning existing medications.

Accredo, Express Scripts Specialty Pharmacy, is Community Health Options preferred specialty pharmacy. Medications denoted as Mandatory Specialty Pharmacy (MSP) on our formulary must be filled using Accredo Pharmacy*. The Accredo Physician Service Center can be reached regarding specialty drug services at (844)-516-3319.

**Note: For drugs identified as a Limited Distribution Drug (LDD), an alternative pharmacy may be used if not stocked by Accredo.*

Specific information available by contacting Community Health Options' Provider Relations* includes, but is not limited to:

- Information related to new drugs, or existing formulary products
- Formulary status of medication
- Drug manufacturer recalls
- Information on pharmacy benefits for specific Members
- Answers to questions regarding prescription coverage, or quantity limitation
- Additional benefits, such as mail-order prescriptions or specialty drugs
- The Prior Approval process for certain formulary or restricted drugs
- Cost-savings options for patients, whether by mail order or Community Health Options' programs.

**Clinical related requests would be referred to the pharmacy or medical management teams.*

Our PBM offers a Real-Time Prescription Benefit (RTPB) solution which can deliver Member-specific benefit information into a provider's prescribing workflow through the Electronic Health Record (eHR). This solution brings actionable data to the point-of-care, providing access to:

- Member out-of-pocket costs
- Coverage alerts (Prior Authorization required)
- Therapeutic options
- Pharmacy options

Access to the RTPB solution can be activated by discussing this option with your EHR vendor.

Formulary Changes

Formulary changes are made each year in January and July. These changes will be provided in the Community Health Options' Provider Bulletin and can be provided upon request by contacting Provider Relations. A minimum of 60 days' advance notice is provided to Members using medications being removed from the formulary or when there is a change that could result in a negative impact for the Member. No advanced notice is provided when the approval or withdrawal of a medication is made by the Food and Drug Administration (FDA) or when a brand name drug becomes a multi-source brand (an FDA-approved generic equivalent is available).

What if a Drug is Not Listed on the Formulary?

Potential reasons a drug is not listed on the Formulary:

- It is excluded from both pharmacy and medical benefits.
- It is excluded from the pharmacy benefit, but it may be covered under the medical benefit. These tend to be infusions and injections that are not filled by a pharmacy. They are usually administered in a Provider's office or in an outpatient setting.
- It is not listed on the formulary, but it is not explicitly excluded from the pharmacy benefit. It may be eligible for a formulary exception review.

Requesting Prior Approval & Formulary Exceptions

Community Health Options' PBM, Express Scripts, maintains a process by which healthcare providers can:

- Request Prior Approval for medication(s) designated in the formulary by a Prior Authorization (PA), Step Therapy (ST) or Quantity Limit (QL).
- Request a formulary exception for drugs used for an off-label purpose, and drugs not included in the Community Health Options then-current drug Formulary.

Healthcare providers can initiate such requests by contacting Express Scripts:

- Telephone- Express Scripts Prior Authorization Line - (800) 753-2851
- Electronic Prior Authorization (ePA) – www.esrx.com/pa
- ExpressPAth - https://www.express-path.com
- Cover my meds - https://www.covermymeds.com/
- SureScripts - https://providerportal.surescripts.net/ProividerPortal/login
- Prior Authorization forms are available to providers on our website at https://www.healthoptions.org/providers/resources/ under the forms section.

Information required to process a prior authorization and exception request includes:

- Requesting provider's name and telephone number
- Member's Community Health Options ID number, name, and date of birth
- The medication requested, including dosage and frequency.
- Supporting clinical rationale, which may include, but is not limited to, relevant pages from the medical record, laboratory studies, prior medication treatment history and other documentation, as determined by Community Health Options.

Prior Approval & Formulary Exceptions Process

Prior Approval requests are required for formulary drugs with a PA, ST, or QL designation. Formulary exception requests may be made when a drug is considered non-formulary. Exceptions requests will be evaluated on a case-by-case basis and determination of coverage is made utilizing the following criteria:

- Member eligibility at the time of the request
- Consideration of Member Benefit Agreement exclusions
- Coverage may be provided in situations where one of the following conditions is met:

  1) The Member has had an adverse reaction, allergy or is intolerant to the Formulary drug or preferred alternative; or
  2) The Member has tried and failed an available formulary drug or a preferred alternative; or
  3) The Member is stabilized on a non-formulary or non-preferred drug AND transitioning to a formulary drug or preferred alternative would pose a clinical risk.
- Express Scripts' medical necessity criteria

A representative from Community Health Options' PBM will perform the initial review of the necessary information and assemble documents necessary to recommend a course of action. A licensed provider shall make the final decision in those instances where the decision results in a denial based on medical necessity and appropriateness. Based on the determination of coverage made, one of the following will occur:

If the request is approved:

- Prior Approval will be entered into the pharmacy claims adjudication system.
- The Member (or Member's authorized representative) and provider will be notified of the determination of coverage.
- A written confirmation of the approval will be sent to the provider and Member.

If the request is denied, resulting in an adverse benefit determination, the following will occur:

- The healthcare provider and Member (or Member's authorized representative) will be notified via phone, mail, or fax of the adverse determination.
- The prescribing healthcare provider can discuss the determination of coverage with a Community Health Options PBM pharmacist or medical director.
- The Member (or Member's authorized representative) and healthcare provider will be sent a written notification of the adverse benefit determination within two business days of the decision being made. The written notification shall include, but not limited to:
    - The principal reason(s) for the decision
    - Reference to criteria on which the denial is based.
    - Clinical rationale for denial
    - Information on how to request a re-consideration.
    - The protocol relied upon for the determination is available on request.
    - Instructions regarding initiation of the appeal process
    - Instructions regarding the peer-to-peer process

Important Pharmacy Links:

Medication Benefit Management Guide
Medication Prior Approval Form (medical via Health Options)
Medication Prior Approval Form (Pharmacy via Express Scripts)

Medical Management & Quality Improvement/Accreditation

Population Health

Community Health Options' Care Management team is available to provide additional support to:

- Members who have experienced a new medical event or diagnosis that requires extensive use of resources.
- Members with complex health needs may benefit from having additional care coordination support.

Our care management philosophy supports Members receiving care coordination services in their own community with trusted local resources. Our clinical specialists and professional support staff strive to maintain close working relationships with care managers to leverage the quality work done at the local level to avoid duplication of service, minimize Member confusion and optimize care coordination.

When a Member is identified for Complex Case Management (CCM) services, a Community Health Options clinical specialist coordinate care with a care manager. Our team will inform the care manager that a patient in their practice has been identified for CCM services. Our clinical specialist will consult the care manager and inquire about pertinent medical history, known psychosocial needs and personal preferences that may impact effective self-management and adherence to the prescribed treatment plan.

Members, caregivers, and providers can make referrals to the Community Health Options Care Management team or seek further information about our care management services by calling (855) 624-6463 during routine business hours. After-hours referrals and inquiries are received via confidential voice mail and forwarded to the Care Management team the next business day.

Quality Improvement Program

The purpose of Community Health Options' Quality Improvement Program (QIP) is to provide necessary structure and systematic processes to identify, monitor, evaluate, and improve the quality and appropriateness of all clinical and administrative services. Our QIP is designed to ensure compliance with the National Committee for Quality Assurance (NCQA) Health Plan Standards and all applicable federal and state regulations.

Community Health Options QIP is based upon our mission to partner with people, businesses and health professionals to provide affordable, high-quality benefits that

promote health and well-being. In accordance with the Affordable Care Act (ACA), WE employ a quality improvement strategy to prevent hospital readmissions, improve patient safety, reduce medical errors, enhance wellness, reduce healthcare disparities, which may include increased reimbursement or other incentives for improved health outcomes.

Community Health Options' QIP is integrated within all health plan operations and provides structure and authority to ensure effective coordination of quality improvement initiatives, including:

- Access to care
- Care Management/Coordination and Complex Case Management
- Clinical quality measures (e.g., HEDIS)
- Continuity and coordination of medical and behavioral health care
- Credentialing
- Integrated medical and behavioral health.
- Maintaining accreditation status
- Member complaints and appeals
- Member experience ratings (e.g., Qualified Health Plan (QHP) Enrollee Experience Survey)
- Network adequacy
- Population Health Management
- Quality assurance
- Utilization Management

HEDIS (Healthcare Effectiveness Data and Information Set) is comprised of standardized performance measures that compare the performance of managed care plans and physicians. HEDIS is widely used in the managed care industry and developed and maintained by the NCQA. The Community Health Options Quality and Accreditation team is responsible for collecting clinical information from provider offices in alignment with the most current HEDIS specifications. Providers may get requests for medical records to support HEDIS measures annually, starting in December. All records are required to be returned within five business days to allow ample time for any needed follow-up requests. HEDIS measure results provide actionable information to improve the quality of services provided. Results also allow consumer comparisons of quality outcomes across various health plans.

Medical Record Documentation Guidelines

Community Health Options adopts NCQA medical records requirements as minimum acceptable standards, as identified below. Medical records must be maintained in a manner that is current, detailed and organized to perform reviews for patient care and quality purposes. We reserve the right to access the provider's medical records for Members.

1. Patient Identification: Each page in the record contains the patient's name and ID number.
2. Personal/Biographical Data: Include the address, date of birth, sex, employer, home and work telephone numbers and marital status.
3. Provider/Author Identification: All entries in the medical record contain the author's identification with associated credentials. Author identification may be a handwritten signature, unique electronic identifier, or initials.
4. Entry Date: All entries are dated.
5. Legible: The medical record is legible to someone other than the writer.
6. Problem List: Significant illnesses and medical conditions are indicated on the problem list.
7. Allergies/Adverse reactions: Every dose of medication administered, and any adverse drug reaction or allergy noted in the record. Note no known allergies (NKA), if applicable.
8. Past Medical History (patients seen three or more times): Past medical history should be easily identified and includes serious accidents, operations, illnesses, and family history of disease.
9. Alcohol/Tobacco/Substance Use (patients seen three or more times): Notation concerning the use of tobacco, alcohol, and substances for patients 12 years and older.
10. History & Physical Exam/Treatment Plan: The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints and treatment plan documentation is consistent with diagnosis and findings.
    a. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
11. Diagnosis: Relevant diagnoses/conditions established upon admission, during care, treatment, and services.
12. Orders: Laboratory tests and other studies are ordered, as appropriate, with notated completion and results.

13. Consultations: If a consultation is requested, there is a note from the consultant in the record. Records are reviewed for under or overutilization of consultants.
14. Follow-up Care: Encounter forms/notes have a notation regarding follow-up care, calls, or visits with the specific time of return noted in weeks, months or as needed.
    a. Unresolved problems from previous visits are addressed in subsequent visits.
    b. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
15. Immunization Record: An immunization record (for children) is up-to-date, or an appropriate history has been made in the medical record (for adults).
16. Preventive Screening (patients seen three or more times): Evidence that preventive screening and services are offered in accordance with state and federal guidelines.
17. Advanced Directives (patients 21 and older only): Evidence that patient was asked if he/she has an advance directive (health care decisions document).

The provider shall give Community Health Options or its designee copies of or access to provider records at no charge, within 30 days from the date of the request.

Online Tools

Community Health Options is continually providing updated functionality for Members and providers on its website, healthoptions.org. It allows providers to access a variety of online information, resources, and tools.

Community Health Options Website	healthoptions.org
Provider Portal	https://provider.healthoptions.org

Website Information

Community Health Options offers a Provider Portal, through Availity. Registered providers can access:

- Benefit plan information, including cost-sharing amount.
- Claim status.
- Eligibility: Member status
- Forms and guides
- Formulary
- Online authorizations: electronic submissions history
- Other specific informational updates
- Policies and procedures

- Provider bulletins

For more information about the provider portal, please contact the Provider Relations department at via e-mail at: Provider@healthoptions.org.

Availity Registration

Because certain provider information is secured, providers must enter specific identification information as a part of the registration process, to access all sections of the website. After successfully entering the required information, providers will be able to establish a user ID and password to complete the registration and login process.
Availity Registration Instructions

Provider Portal Training

Availity, Community Health Options provider portal, has resources including free on-demand training, frequently asked questions, onboarding modules, and so much more. 'Help & Training' in the top right corner, choose 'Get Trained' then type onboarding in the search catalog field.

Claims

Claim Forms & Field Requirements

A CMS-1500 or CMS-1450 (UB-04) claim form is required to include the applicable data elements as listed in this section and current coding conventions, such as the then-current ICD/CPT®/HCPCS/REV, diagnosis, and procedure coding to the highest level of specificity, as applicable to the diagnosis, for all services reported.

Community Health Options follows the standard requirements for completing claim forms as defined by NUBC (National Uniform Billing Committee) and NUCC (National Uniform Claim Committee). Appropriate forms and data elements must be present for a claim to be considered a clean claim for reimbursement. If claims submitted with missing required fields, claims may be denied.

CMS-1450 (UB-04) Sample form available on the CMS Website
CMS-1500 Sample form available on the CMS Website

Claim Submission

Providers are required to submit claims to Community Health Options for all services rendered to Members. Claims must be submitted in accordance with our policies and

national billing standards (CMS, National Uniform Billing Committee (NUBC), and National Uniform Claim Committee (NUCC).

The initial submission of any claim must be received by Community Health Options within 120 days of:

- The date of service for outpatient claims
- The date of discharge for inpatient claims
- The date of the primary EOP when Community Health Options is not the primary payer.

Electronic Claim Submission

Health Options' Electronic Data Interchange (EDI) program allows providers to submit claims electronically through an approved clearinghouse vendor. Electronic claim submission to Health Options must be in a format that is required by the Health Insurance Portability and Accountability Act ("HIPAA") or other regulation and in accordance with Health Options' policies and procedures to be considered a clean claim for processing.

For claim status, Providers should use Community Health Options' electronic portal as the primary source for any claim submitted for payment.

Community Health Options payor ID for medical claims submissions: 45341.

Paper Claim Submission

If a provider does not have the capability to submit claims electronically, claims may be submitted via mail using a CMS-1500 or CMS-1450 (UB-04) claim form to the following:

Medical & Behavioral	Community Health Options Mail Stop 200 PO Box 1121 Lewiston, ME 04243
Dental	Northeast Delta Dental PO Bo 2002 Concord, NH 03302-2002

Healthcare providers (facilities, physicians, and other health care professionals) are responsible for accurately and timely: documenting, billing, and coding by following

industry standard guidelines, including but not limited to AMA, CPT, HCPCS, CPT Assistant, NUBC, Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, NCCI table edits and other CMS guidelines for appropriate claims review processing by Community Health Options.

Claim Reimbursement Policies and Billing Guidelines

Community Health Options' requirements for professional and facility type claims billing guidelines, processing, and reimbursement are published online at healthoptions.org, under Providers > Resources > Policies and Procedures.

Community Health Options may deny payment for any services or supplies for which a provider failed to comply with our policies and procedures and has the right to revise policies when necessary.

Claim Submission Reminders

Reduce potential claim denials or delays in processing by ensuring proper claim submission with the following:

Coding

Ensure claims are submitted utilizing the most current versions of the Current Procedural Terminology (CPT) codes, appropriate Health Care Common Procedure Coding System (HCPCS)

Duplicate Submissions

Avoid submitting a claim multiple times to prevent possible duplicate denials. You can check claim status via the Provider Portal or by calling our Service Center at (855) 624-6463.

Drug Charges

Include a valid National Drug Code (NDC) for medical drugs on hospital outpatient and professional claims.

Modifiers

Ensure correct reimbursement and avoid potential denials by including appropriate and required modifiers.

Type of Bill Codes

When billing facility claims, ensure the type of bill code supports the revenue codes that are billed on the claim. For example, if billing outpatient revenue codes, the bill type must be for outpatient services.

Interim and Split Billing

Be sure to submit a claim with the appropriate type of bill for the billing period (locator 4) including interim, continuing interim and final interim. Statement Coverage Period (form locator 6) should include the from date (start date of care/admission date or first day of the subsequent month) and through date (months end or date of discharge), Admission/Start Date of Care (locator 12) and Patient Discharge Status (locator 17)
Interim and split claims should not include charges that were submitted on a prior claim since the subsequent billing date range begins the first day of the following month and bill dates should be aligned with charge dates.

Other Insurance Coverage

When submitting a claim with other insurance information, please ensure the following claim fields and information is completed. Also be sure to include a copy of the Explanation of Benefits (EOB) from the other insurance coverage along with the claim:
CMS-1500 Fields

1. Field 9: Other Insured's Name
2. Field 9a: Other Insured's Policy or Group Number
3. Field 9b: Other Insured's Date of Birth
4. Field 9c: Employer's Name or School Name (not required in EDI)
5. Field 9d: Insurance Plan Name or Program Name (not required in EDI)

UB-04 CMS-1450 Fields

1. Field 50a-c: Payer Name
2. Field 54a-c: Prior Payments (if applicable)

Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB)

Claim Reimbursement and Payments

Health Plan Reimbursement

Providers are reimbursed for the provision of medical services to Members pursuant to the payment provisions of their Agreement. Providers may collect from Members amounts for specified non-covered services, copayments, coinsurance and/or deductibles that may be due from a Member in accordance with the Member's benefit document.
A Member's cost sharing amount appears on the provider's explanation of payment (EOP) generated by Community Health Options in response to reported services. The

reimbursement, in conjunction with applicable Member cost sharing amounts for Covered Services, constitutes payment in full.

Providers should contact the Service Center at (855) 624-6463 with any questions about their payments.

Non-Covered Services

Neither Community Health Options nor an employer shall have any obligation to pay for services that a Member is not entitled to under the terms of a valid benefit document. Such services are considered non-covered services. Providers are required to advise a Member that a service is not a covered benefit before performing the procedure, and to obtain Agreement from the Member that they are solely liable for payment. However, claims denied due to provider's failure to meet Community Health Options' prior approval, concurrent review and/or retroactive review process are not considered non-covered services and provider agrees that it will not hold Members liable for payment of such denied claims.

Reimbursement/Fee Schedules

Reimbursement or fee schedules are rates agreed upon within the provider's contract with Community Health Options. A fee schedule is a list of predetermined rates that the health plan utilizes to determine reimbursement. Reimbursement is calculated using the negotiated rate within the provider's contract for covered services outlined in the Member's benefit document. Services determined to be non-covered according to such benefit document are not reimbursable by Community Health Options and is the financial responsibility of the Member.

Professional Site of Service Payment Differential

Site of service payment differential is a reimbursement methodology utilized by Medicare and other health insurance payors to maintain equity of reimbursement for certain services when performed in different settings (e.g., physician's office, hospital, ambulatory surgery center, etc.). Community Health Options may apply this reimbursement methodology to certain services as deemed appropriate.

Member Financial Responsibility

To determine a Member's financial responsibility, please refer to the provider portal online at https://www.healthoptions.org/providers/overview/ or via your provider payment portal www.instamed.com

The Community Health Options EOP will reflect the Member's copayment, deductible and/or coinsurance amounts owed for the services reported. In addition, any service/charge determined to be a non-covered service in accordance with the Member's benefit document, will be the Member's financial responsibility.

Providers are required to notify Members of credit balances and/or provide refunds of such credit balances to the Member that were a result of the provider's collection of amounts not owed by Member for covered services.

Electronic Funds Transfer

Community Health Options issues payments via paper check or electronic fund transfer EFT. Claim payments are faster and easier through our electronic fund transfer (EFT) system. Register for EFT at https://register.instamed.com/eraeft.

Interest Penalty for Late Payment

Community Health Options follows state and federal regulations related to any interest that may be due on clean claims.

Refunds / Recoupments

When an overpayment on a claim occurs through a corrected or voided claim, refund check or recoupment request from a provider, a receivable is created and notice to the provider will be sent either through the Explanation of Payment (EOP)/Remittance Advice and a letter in certain instances. Any receivable that is outstanding after 30 days from notification will be recouped from future claim payments. The recoupment will appear on a future EOP/Remittance identifying the forwarding balance and any claim that applied towards that balance.

Please call the Service Center at (855) 624-6463 to inquire about a claim recoupment or receivable balance.

Fraud, Waste, & Abuse (FWA)

What is Fraud, Waste and Abuse?

Fraud: Deceptions or misrepresentations made by a person or entity that knows or should know that the deception or misrepresentation could result in unauthorized benefit to himself/herself or other person(s) or entity(ies) constitutes fraud.

Waste and Abuse: Incidents or practices that are inconsistent with legal, ethical, accepted and sound business, fiscal or medical practices that result in unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes plan member practices that result in unnecessary costs to a health program.

Community Health Options is committed to a policy of zero tolerance for fraudulent insurance acts that harm Community Health Options and its stakeholders. Accordingly, we maintain an FWA Program, and any claim submission is subject to review. The primary role of the FWA Program is to identify suspected fraud, waste, or abuse, analyze and evaluate the circumstances, and take appropriate action to ensure Community Health Options and its stakeholders are not harmed and that any necessary corrective actions are implemented. Our FWA Program follows applicable state and federal regulations.

Medical Care Provided Within the Family

Physicians should not treat themselves or Members of their own family. Any attempt to bill for such services will not be eligible for reimbursement. Family Members also may not select an immediate family Member as a Primary Care Physician (PCP).

Claim Appeals and Reconsiderations

Community Health Options is responsible for the oversight of all appeals and reconsiderations relating to adverse benefit and adverse health care treatment determinations that have been decided by Community Health Options as well as our delegated partners.

Claim reconsiderations may be submitted by providers on behalf of a Member. Members are not notified when a provider submits a claim reconsideration. To be considered, claim reconsiderations must be filed within 90 calendar days of the adverse determination. The 90-day count commences with the date denoted in the applicable EOB, or the EOP notice.

Appeals may be submitted by Members, authorized representatives or providers on behalf of Members. To be considered, appeal requests must be filed within 180 calendar days of the adverse determination. The 180-day count commences with the date denoted on the

applicable Authorization denial letter, Explanation of Benefits (EOB), or the Explanation of Payment (EOP) notice.

For more information on Appeals and Reconsiderations, see our full policy Appeals & Reconsiderations found on our website under Provider Resources.

Policies

Acute Isolation Room & Board Charges
https://healthoptions.org/mediapath/providerguides/acuteisolationroomboardcharges/

Ambulance Services
https://www.healthoptions.org/mediapath/providerpolicies/ambulanceservices/

Anesthesia Professional Services
https://healthoptions.org/mediapath/providerpolicies/anesthesiaprofessionalservices/

Clinic Charges
https://healthoptions.org/mediapath/providerpolicies/cliniccharges/

Coordination of Benefits
https://healthoptions.org/mediapath/providerguides/coordinationofbenefits/

Facility Revenue Code Requirements
https://healthoptions.org/mediapath/providerguides/facilityrevenuecode/

Hearing Aid Billing Guidelines
https://healthoptions.org/mediapath/providerpolicies/hearingaidbilling/

Hospital Outpatient Observation
https://healthoptions.org/mediapath/providerforms/hospital-outpatient-observation-reimbursement-policy/

Interim Billing & Split Claim
https://healthoptions.org/mediapath/providerpolicies/interim&splitbilling/

Itemized Bill Submission
https://healthoptions.org/mediapath/providerguides/itemizedbillsubmission/

Medical Policy: Adverse Utilization Management Decisions
https://healthoptions.org/mediapath/providerpolicies/adverseumdecision/

Medication Assisted Treatment
https://healthoptions.org/mediapath/providerguides/medication_assisted_treatment%20external.pdf/

Modifier Reference Guide
https://healthoptions.org/mediapath/providerpolicies/modifierreferenceguide/

NDC Drug Billing Guidelines
https://healthoptions.org/mediapath/providerpolicies/ndcbilling/

Outpatient & Professional Service Edits
https://healthoptions.org/mediapath/providerguides/outpatient&professionalserviceclaimedits/

Professional Services
https://healthoptions.org/mediapath/providerpolicies/professionalservices/

Paper Claims Submission
https://healthoptions.org/mediapath/providerguides/paperclaimssubmission/

Payment Integrity Audit
https://healthoptions.org/mediapath/providerpolicies/paymentintegrityaudit/

Physician Assistant Services
https://healthoptions.org/mediapath/providerpolicies/physicianassistantservices/

Preventable Adverse Events (“Never Events” / Hospital Acquired Conditions)
https://healthoptions.org/mediapath/providerguides/preventableadverseevents/

Replacement Claim Billing
https://healthoptions.org/mediapath/providerguides/replacementclaimbilling/

Routine Supplies, Services, and Medical Equipment
https://healthoptions.org/mediapath/providerpolicies/routinesuppliesservicesmedequipment/

Surgery: Computer-Assisted / Robotic
https://healthoptions.org/mediapath/providerpolicies/surgerycomputerassistedrobotic/

Telemedicine / Telehealth Services
https://healthoptions.org/mediapath/providerpolicies/telemedtelehealthservices/

Urine Drug Testing
https://healthoptions.org/mediapath/providerguides/urinedrugtesting/

Unlisted / Unspecified / Misc. Codes
https://www.healthoptions.org/mediapath/providerpolicies/unlistedcodes/

Glossary

Active Case Management Case: When a Member who has been identified as eligible for complex case management accepts participation in the Complex Case Management (CCM) program.
Adverse Benefit Determination: A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit. This may include rescission of coverage.
Adverse Coverage Decision: Include adverse healthcare treatment decisions based on medical necessity review and adverse benefit determinations related to coverage by the Member's health plan.
Adverse Health Care Treatment Decision: A healthcare treatment decision that denies in whole or in part payment for or provision of otherwise covered services requested for a Member. A healthcare treatment decision means a decision regarding diagnosis, care or treatment when medical services are provided as well as benefit decisions involving medically necessary healthcare, preexisting condition determinations and determinations involving experimental or investigational services.
Agreement: The agreement to provide healthcare services, together with any attachments, exhibits, applicable Provider Manual(s), benefit documents, as amended from time to time and made a part of the agreement by reference between contracted healthcare provider and Community Health Options.
Ambulatory Surgical Center: A facility or portion thereof not located upon the premises of a hospital which provides specialty or multi-specialty outpatient surgical treatment. This does not include individual or group practice offices of private providers or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

Ambulatory Surgical Center Provider: An ambulatory surgical center licensed, certified, or otherwise regulated under the laws of the state in which it operates, that has an agreement with Community Health Options to provide covered services to Members.
Appeal: An appeal is a request by a Member, authorized Member representative or healthcare provider (with the consent of the Member) to have Community Health Options or a certified utilization review entity reconsider a denial decision. Appeals include adverse healthcare treatment decisions and adverse benefit determinations related to coverage by the Member's health plan. An appeal does not include a complaint. Appeals may occur prior to rendering a medical service (pre-service) or after a medical service is rendered (post-service). Appeals may be standard or expedited. Appeals also include external reviews conducted by an independent third-party.
Approved Holidays (Community Health Options)**:** New Year's Day, Memorial Day, Juneteenth, July 4th, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day.
Benefit Document(s): The Member Benefit Agreement, schedule of benefits and any rider(s) thereto and/or summary plan document which sets forth the terms, conditions, and benefits of coverage for Members enrolled in Community Health Options.
Billed Charges: Those charges, determined prior to deduction for discounts and contractual adjustments, which are usually and customarily billed by a provider to all his/her patients for a particular service, as adjusted from time to time.
Board Certification: The successful completion of a process by which providers are certified in a given medical specialty or subspecialty. Organizations that may grant board certifications recognized by Community Health Options include, but are not limited to, the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, and the American Association of Physician Specialists.
Business Associate: A person or entity who, on behalf of Community Health Options, performs, or assists in the performance of, a function or activity involving the use of a resident's/participant's health information, or who provides services to Community Health Options that require the disclosure of a Member's health information. Our employees are not business associates. Examples of business associates are persons or entities that perform the following services to or on behalf of Community Health Options: claims processing or administration, data analysis, utilization review, quality assurance, billing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services.
Business Day: Any day of the week other than Saturday, Sunday, or a legal holiday when commercial banks in the State of Maine are open for business.
Community Health Options Call Center Hours: 8 a.m. to 6 p.m, Monday through Friday, except for Community Health Options Holidays (see above).

Care Manager: A Community Health Options care manager is a Maine-licensed registered professional nurse responsible for gathering all pertinent information for coordinating Member care needs in accordance with the Complex Case Management Policy.
Case Management: Member-centric, collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and coordination of available resources to promote high-quality, cost-effective health outcomes.
Chronic Medical Condition: Human health condition or disease that is persistent or otherwise long-lasting in its effects. The term *chronic* is usually applied when the course of the disease lasts for more than three months. Examples of chronic diseases include Asthma, Chronic Obstructive Pulmonary Disease (COPD)/Emphysema, Diabetes and Hypertension.
Clean Claim: A claim for payment for a covered service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a healthcare provider who is under investigation for fraud or abuse regarding that claim.
Clinical Guidelines: Systematically developed statements to assist a provider and patient in making decisions about appropriate healthcare for specific clinical circumstance(s).
Coinsurance: A form of cost sharing which requires the Member to pay a portion of the cost of covered services. Coinsurance is a set percentage of this cost.
Company: Shall mean Community Health Options.
Complaint: An oral or written dissatisfaction with the health plan by a Member. Complaints can be regarding a provider, coverage issues, including contract exclusions, limitations and benefits that are not covered, along with the operations and/or management of Community Health Options and has been filed with the company or the Maine Bureau of Insurance. A complaint does not include an appeal.
Concurrent Review: A medical management technique used by managed care organizations to ensure that medically necessary and appropriate care is delivered during a Member's hospitalization or other episode of care.
Copayment: A form of cost sharing which requires the Member to pay a fixed amount of money for a covered service. Copayment amounts are due at the time and place of such services that a Member receives, or may be subsequently billed by a provider, at the provider's sole discretion.
Covered Person: An individual eligible to receive covered services or other benefits under the terms of the applicable benefit documents as the subscriber or an eligible enrolled family dependent. A covered person may also be referred to as a Member.
Covered Service: A medically necessary (unless otherwise indicated) service or supply specified in a Member's subscription certificate for which benefits will be provided

pursuant to the terms of a subscription certificate or any medically necessary supplemental health services set forth in any riders supplementing a subscription certificate.
Credentialing: The administrative process that supports the collection, verification, review, and evaluation of an individual's or organization's credentials.
Credentialing Verification Organization (CVO): An entity to which Community Health Options delegates certain Credentialing functions for providers and organizations to be conducted in accordance with standards established by the National Committee for Quality Assurance ("NCQA") and the Centers for Medicare and Medicaid Services (CMS).
Credentials: Records of an individual's or organization's education, training certifications, licensures, experience, and other healthcare qualifications, as applicable.
Criteria: An accepted set of standards, guidelines or protocols used by Community Health Options to guide the CCM process.
Custodial (long-term) care: A variety of services that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or nursing homes.
Deductible: A specific dollar amount that must be incurrent and paid by a Member or a Member's family before Community Health Options will assume any liability for all or part of the cost of covered services.
Delegation Agreement: A mutually agreed upon written document that outlines roles, responsibilities and reporting requirements for delegates who perform NCQA standard activity on behalf of Community Health Options.
Delegated Entity: A corporation, limited liability company, partnership, or other organization or entity to which Community Health Options delegates any Credentialing function(s).
Delegation: The process by which Community Health Options gives another organization the authority to perform certain functions. We formally contract with such organizations and enters into a delegation agreement with the other organization that specifies the duties and responsibilities of Community Health Options and the organization.
Disclosure: The release, transfer, provision of access to, or divulging in any other manner of health information outside of Community Health Options.
Disease Management: Is a Member-centric, multi-disciplinary continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. It supports the Member-provider relationship and plan of care. It continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health and wellbeing of Members.

Disease Management Manager: An organization that provides outreach and coaching services to Community Health Options' plan Members to help them manage a chronic disease.
Community Disaster Recovery Team: An internal team of managers and directors who manage Community Health Options operations in the event of emergencies.
Durable Medical Equipment: Equipment designed to serve a medical purpose, and which is not useful for a Member in the absence of illness or injury, is able to withstand repeated use, is appropriate for use in the home and is not a disposable supply.
Electronic Protected Health Information (EPHI): Electronic versions of *protected health information* (see definition below). Sometimes referred to as protected health information (PHI).
Emergency: A medical condition with acute symptoms of severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the Member, or, with respect to a pregnant woman, the health of the Member or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any organ or body part.
Emergency Services: Any healthcare service provided to a Member that can be defined as an emergency (see above). Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described in this definition.
Employer: An employer who has an agreement with Community Health Options for the provision of third-party administrative services by Community Health Options, and access to the Community Options Network for employer's health benefits plan(s).
Employer-Sponsored Program: A program established and maintained by an Employer to provide its Members with healthcare benefits which may be subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).
Evidence-Based Guidelines: Clinical practice guidelines known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence or by professional standards in the absence of scientific evidence, or by expert opinion in the absence of professional standards.
Family Relationship: Related or connected by blood, marriage or adoption to include both immediate and extended family Members.
Formulary: A continually updated list of prescription medications that represents the current covered drugs by Community Health Options based upon the clinical judgment of our Chief Medical Officer. The formulary contains brand name drugs and generic drugs, all of which have been approved by the Federal Food and Drug Administration (FDA).
Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or

another person. It includes any act that constitutes fraud under applicable federal or state law.

Governmental Agency: Shall refer to the Maine Bureau of Insurance, the Centers for Medicare and Medicaid services or other government departments or their respective agents with direct responsibilities to access records for the purpose of quality assurance, investigation of complaints or appeals, enforcement or other activities related to compliance with applicable laws and regulations and shall specifically include the National Committee for Quality Assurance, as applicable.

Group: The employer, association, union, or trust through which a Subscriber is enrolled.

Harmful Effects: The definition of harmful effects is debatable. As it relates to the breach of privacy or an individual's protected health information, harmful effects may be determined by the impact of an unauthorized use or disclosure of PHI on such things as reputation, the safety of the person and significant others, health, employability, financial and social status and emotional distress.

Healthcare Operations: Any of the following of Community Health Options:

1. Conducting quality assessment and improvement activities, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment.
2. Reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs under supervision to practice or improve skills, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities.
3. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
4. Business planning and development; and
5. Business management and general administrative activities of Health Options, including but not limited to: (i) customer service; (ii) resolution of internal grievances; (iii) due diligence in connection with the sale or transfer of assets to a potential successor in interest; and (iv) creating de-identified health information, fundraising for the benefit of Health Options, and marketing for which an individual authorization is not required.

Healthcare Provider: A licensed hospital or healthcare facility, medical equipment supplier or person who is licensed, certified, or otherwise regulated to provide healthcare services under any applicable law including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse provider, registered nurse, nurse midwife, physician's

assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

Healthcare Service: Any covered treatment, admission, procedure, medical supplies and equipment, or other services, including behavioral health, prescribed, or otherwise provided or proposed to be provided by a healthcare provider to a Member as deemed medically necessary.

Health Coach: A health professional who facilitates healthy, sustainable behavior changes by challenging a Member to listen to their inner wisdom, identify their values and transform their goals into action.

Health Information: As used in this manual, health information shall mean information that is created or received by Community Health Options that relates to the past, present, or future physical or mental health or condition of a Member; the provision of healthcare to a Member; or the past, present, or future payment for the provision of healthcare to a Member. It also identifies the Member, or with respect to which there is a reasonable basis to believe that the information can be used to identify the Member. Protected Health Information (PHI) is a subset of health information.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law, as may be amended from time-to-time, including, by not limited to, the following: a) limiting exclusions for pre-existing conditions (as defined under HIPAA); b) prohibiting discrimination against employees and dependents based on their health status; c) guaranteeing renewability and availability of health coverage to certain employers and individuals; d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and e) regulating the use and disclosure of protected health information.

Health Maintenance Organization (HMO): An organized system that combines the delivery and financing of healthcare and which provides or arranges for the provision of basic health services to voluntarily enrolled Members for a fixed prepaid fee.

Health Plan: Shall refer to Community Health Options.

Home Health/Hospice Provider or Home Health Provider or Hospice Provider: A Medicare-certified agency under Agreement with Community Health Options which provides:

- Intermittent skilled nursing services and other therapeutic services in a Member's home when medically necessary; and when authorized by a provider unless otherwise permitted in accordance with the terms and conditions set forth in a Member's benefit document; and/or
- Hospice services, as applicable.

Home Health Services: Medically necessary healthcare services, which are:

- Rendered in the Member's place of residency by healthcare personnel.
- Provided in accordance with the Member's benefit document.

- Rendered in accordance with a treatment plan established by a Home Health Provider and Member's physician.
- Authorized (when required) by the Medical Management department.

Home health services may include the administration of home infusion, as applicable.

Hospice: Means a covered service rendered by a contracted provider who is licensed as a provider of hospice services in the state of Maine and is a certified provider of hospice services under Medicare.

Hospice Services: Medically necessary healthcare services which are:

- Provided in accordance with a Member's benefit document.
- Rendered in accordance with a plan of care established by a hospice provider and a Member's physician.
- Rendered for conditions related to the terminal illness; and
- Provided in accordance with the Member's executed advance directive.

Hospital: An institution which:

- Provides diagnostic, surgical, and therapeutic services for the diagnosis, treatment, and care of injured or ill persons by or under the supervision of physicians; and
- Is licensed, certified, or otherwise regulated to provide such services and to operate as a hospital under the laws of the state in which it operates and/or federal laws, as applicable.

The term "hospital" excludes skilled nursing facilities, convalescent nursing homes, custodial care homes, health resorts, spas and sanitariums.

Hospital Provider: A hospital that has an agreement with Community Health Options to provide covered services to Members.

Hospital Services: The covered services to be provided by hospital provider to Members as set forth in the Agreement.

Identification Card: The card issued by Community Health Options to identify Members enrolled in a Community Health Options health plan, employer-sponsored program, or member of a self-funded plan administered by Community Health Options. Possession of an identification card confers no right to covered services or other benefits under Community Health Options or an employer-sponsored program. To be entitled to covered services or benefits, the holder of the card must, in fact, by a Member on whose behalf all applicable premiums under the benefit document have been paid; or with respect to an employer-sponsored program, be an enrolled Member on whose behalf all amounts due to Health Options have been paid by an employer.

Incident: An occurrence that actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system, or constitutes a violation or imminent threat of violation of law, security policies, security procedures or acceptable use policies.

Informal Copy(ies): Any duplicate or additional copies of a record, usually referring to PHI.

Information System: Is defined as an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.
Inpatient Admission: hospital or skilled nursing facility (with anticipated discharge) for medical services.
Interactive Contact: Is a two-way interaction in which the Member receives self-management support or health education by one or more of the following modes: in-person contact with either individual or group, interactive mail-based communications (e.g., survey), phone (e.g., interactive voice response or live call), online contact (e.g., live chat, secure e-mail).
Intermediate Care: A level of care that is less than the degree of care and treatment that skilled nursing facility is designed to provide, but greater than the level of room and board.
InterQual®: is a proprietary set of guidelines that use clinical indicators to determine medical necessity. InterQual® criteria are based on current clinical principles and processes. InterQual® guidelines are updated yearly by the criteria developers, with review and input by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or guidelines under review.
Loan Agreement: In general, when Community Health Options refers to "the Loan Agreement" it is usually referring to the Agreement with the Centers for Medicare and Medicaid Services (CMS).
Managed Behavioral Health Organization (MBHO): An organization that provides behavioral healthcare services through an organized delivery system across a continuum of care.
Medical Director: A licensed provider designated by Community Health Options to direct its medical and scientific aspects, and to monitor and oversee the quality and appropriateness of managed health services.
Medical Management: The process of evaluating the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures, and facilities under the provision of a health benefit plan. Managing a Member's healthcare by coordinating care, improving continuity and quality of care in the most efficient manner may also be included in medical management. Also known as utilization review or utilization management.
Medically Necessary or Medical Necessity: Covered services rendered by healthcare providers that Community Health Options determines are:

- Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease, or injury.
- Provided for the diagnosis and the direct care and treatment of the Member's condition, illness, disease, or injury.
- In accordance with current standards of good medical treatment practiced by the general medical community.

- Not primarily for the convenience of the Member, or the Member's healthcare provider; and
- The most appropriate source or level of service that can safely be provided to the Member, at the most appropriate time.

When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered of the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medical Services or Professional Services: Those services normally provided by a PCP or SCP in the diagnosis and treatment of Members to the extent that they are medically necessary and covered under the terms of a Member's applicable benefit document. This includes supplies, injections, diagnostic tests and other services and procedures within the scope of the provider's professional competence and normal practice.

Medicare (Program): The programs of healthcare for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

Member: An individual eligible to receive covered services or other benefits under the terms of the applicable benefit documents as a subscriber or an eligible enrolled family dependent. A Member may also be referred to as a covered person.

Member's Designee: Same as Member representative.

Member Representative: Means a person who has been given written legal authority to represent the Member. The treating physician, healthcare provider or organization acting on behalf of the Member is recognized as a Member's representative and may also submit an appeal. Sometimes referred to as Member's designee.

Member Service Department (Service Center): Community Health Options associates who can answer member and healthcare provider questions and provide information regarding Community Health Options and a Member's coverage. The telephone number for the Member Service Department is set forth on the back of the Member's identification card.

Service Center Partner: Refers to the Community Health Options partner contracted to accept Member and provider calls that cannot be answered by Community Health Options service associates because of high volume or the specific nature of the inquiry.

Mitigation: The act of causing an event or circumstance to become less harsh or hostile, or making an event or circumstance less severe or painful.

National Committee for Quality Assurance (NCQA): A nationally recognized quality assurance accreditation organization that provides quality guidelines/standards and surveys health plans to ensure adherence to quality standards.

Network: The contracted providers and organizations who have been credentialed by Community Health Options (or a delegated entity) and have entered into a written agreement with Community Health Options to provide covered services to its Members.

Non-Covered Services: Any service not covered under the terms of a Member's benefit document.
Non-Routine File: A credentialing provider or organization file that does not meet the established threshold for participation in the network.
Non-Urgent Care: Regular or routine care, not including preventive care.
Observation: Observation level of care allows reasonable and necessary time to render medically necessary outpatient services and evaluate a Member's condition to determine admission to inpatient level of care or discharge.
Organization: An institution, facility or other business entity that provides services or supplies to Members and includes, but not limited to, hospitals, home healthcare agencies, and rehabilitation facilities. May also be referred to as a Provider.
Organization Agreement: The written Agreement between Community Health Options and a provider or organization whereby the organization or provider becomes a part of the network. May also be referred to as a Provider Agreement.
Orthotic Device: A device which is a rigid appliance or apparatus used to support, align, or correct bone and muscle deformities.
Provider or Healthcare Provider: A physician, medical group, pharmacy, hospital, or other provider of health service, licensed, certified, or otherwise regulated under the laws of the state in which it operated, that has an Agreement with Community Health Options to provide covered services to Members.
Partner: A business (associate) partner with whom Community Health Options entered into a contractual agreement for services.
Payment: The activities undertaken by Community Health Options to obtain reimbursement for the provision of healthcare.
Payor: An employer, ERISA plan sponsor or trust fund insurance carrier or any other entity that accepts fiduciary responsibility for an established program of health benefits to Payor's insureds/Members, or any other entity which has contracted with Community Health Options to use the Community Health Options provider network.
Personal Acquaintance: One's slight knowledge of or a friendship with someone. For the purposes of this manual prior servicing of the Member as part of the Member Service Associate's job function at Health Options will not constitute a personal acquaintance.
Personal Representative: A person authorized (under State or other applicable law, e.g., tribal, or military law) to act on behalf of the individual in making healthcare-related decisions. May also be referred to as a Member representative or Member's designee.
Pharmacy Benefits Manager (PBM): A third-party administrator (TPA) of prescription drug programs.
Policy: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions, and benefits of coverage, as awarded by Community Health Options to its Members, as applicable. A policy may also be referred to as a Subscription Certificate.

Policy Holder: An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has been received by Community Health Options. A subscriber is known as a Member and policy holder may also be referred to as a subscriber.

Pre-Delegation Evaluation: The evaluation conducted by Community Health Options prior to signing a delegation Agreement, to determine the delegate's capacity to perform delegated activities in accordance with Community Health Options and NCQA standards.

Preferred Provider Organization (PPO): Community Health Options' network-based healthcare program that offers benefits of coverage for certain covered services when obtained by a Member, at the Member's option, either in or out-of-network, subject to the terms and conditions of coverage set forth in the Member's benefit document.

Primary Care Provider (PCP): A provider who, within the scope of the provider's practice:

- Supervises, coordinates, prescribes, or otherwise provides healthcare services to a Member and initiates coordination of specialty care.
- Maintains continuity of care; and
- Is so designated by Community Health Options.

Primary Care Site: The medical office, health center, or other facility or a designated department of a medical facility, staffed by one of more primary care providers, and designated as a primary care site by Community Health Options.

Professional Services or Medical Services: Those services normally provided by a SCP in the diagnosis and treatment of Members to the extent that they are medically necessary and covered under the terms of a Member's applicable benefit document. This includes diagnostic tests and other services and procedures within the scope of the provider's professional competence and normal practice.

Prosthetic Device: A device, which is an externally worn appliance or apparatus, which replaces a missing body part.

Protected Health Information ("PHI"): Individually identifiable health information (as defined by HIPAA), whether oral or transmitted by electronic media, maintained by electronic media, or transmitted or maintained in any form or medium, including demographic information collected from an individual, and:

- Created or received by a healthcare provider, Community Health Options, employer, or healthcare clearinghouse; and
- Relates to the past, present or future physical or mental condition of an individual, as well as the provision of healthcare to an individual, and
- That identifies the individual; or
- With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Provider: A licensed or certified professional who provides behavioral or medical healthcare services, who may be a physician or non-physician. Sometimes referred to as a practitioner.
Provider Agreement: The written agreement between Community Health Options and a provider or organization whereby the organization or provider becomes a part of the network. May also be referred to as an organization agreement.
Provider Manual: A document that provides guidance to providers and organizations about plan benefits and operations as well as additional requirements.
Prudent Layperson: A person who is without medical training and who draws on his or her practical experience when deciding about the need to seek emergency treatment.
Re-credentialing: The periodic credentialing of providers and organizations whose credentials have been initially approved by Community Health Options, for the purpose of maintaining the providers' and organizations' participation in the network.
Recognized Sources: Organizations that develop and promulgate evidence based on clinical guidelines. Such organizations may include but are not limited to professional medical associates, voluntary health organizations and government organizations such as National Institutes of Health, Agency for Healthcare Research and Quality (AHRQ), and the United States Preventive Services Taskforce (USPSTF).
Record: Any written, printed, or graphic matter, in either hardcopy or electronic format, which relates to Community Health Options or any aspect of the business, operations or Community Health Options personnel.
Routine File: A credentialing provider or organization file that meets the established threshold for participation in the network.
Schedule of Benefits: A summary of coverage for a Member that identifies the subscriber, applicable copayment, deductible and coinsurance amount for covered services.
Sensitive Information: Includes, but is not limited to, the following: PHI, EPHI, personnel files, payroll data, financial/accounting records, and other information that is confidential.
Shadow Copy (ies): A copy of a record in electronic format held on an electronic device, such as a handheld PDA, a smartphone, or a USB flash drive, or in e-mail archives.
Skilled Nursing Facility (SNF): A facility which:

- Provides inpatient skilled nursing care, rehabilitation services or other related health services.
- Is licensed, certified, or otherwise regulated to provide such services under the laws of the state of Maine; and
- Is certified by Medicare.

The term skilled nursing facility does NOT include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in activities of daily living.

Skilled Nursing Facility (SNF) Provider: A skilled nursing facility that has an Agreement with Health Options to provide covered services to Members.
Skilled Nursing Facility (SNF) Services: SNF services are certain medically necessary skilled healthcare services which:

- Consist of comprehensive, inpatient care designed for the medically stable Member who requires skilled nursing or skilled rehabilitation services as identified by the then current industry-standard medical review criterion in use by Community Health Options including, but not limited to Interqual® and Medicare guidelines; and,
- Are covered under the terms of a Member's applicable benefit document.

Solicitation: Any conduct by a provider, its agents, employees, assignees, or successors, which may be interpreted as an attempt to persuade Member, employers, groups or others to:

- Discontinue their enrollment with Community Health Options, and/or an employer-sponsored program but continue to obtain healthcare services from the provider; and/or
- Encourage Members to participate in any other prepaid health plan or program of third-party reimbursement.

Specialist: A healthcare provider whose practice is limited to primary healthcare services who has additional postgraduate or specialized training, board certification, or practices in a licensed specialized area of healthcare.
Specialty Care Provider: A provider specialist who provides the necessary evaluation, treatment, and follow-up care for Community Health Options Members.
Standard Organization Contract: The type of contract used by Community Health Options to contract with medical services organizations, such as hospitals.
Standard Provider Contracts: The type of contract used by Community Health Options to contract individual professionals.
Subscriber: An individual who meets the requirements for eligibility, who has enrolled in Health Options, and for whom payment has been received by Community Health Options. A subscriber is known as a Member and may also be referred to as a policy holder.
Subscription Certificate: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions, and benefits of coverage, as awarded by Community Health Options to its Members, as applicable. A subscription certificate may also be referred to as a policy.
Summary Plan Document (SPD): An employer document which sets forth the terms, conditions, and benefits of coverage for Member enrolled through an employer-sponsored program.
24/7 Health (TANS): A 24-hour per day, toll-free telephone number for Members to access nurse advice listed on the Member's identification card. 24/7 Health is not an authorized agent for purposes of coverage determination or appointment scheduling.

Termination: When referring to contracts, includes expiration of the contract term.
Third-Party Administrator (TPA): An organization which performs administrative services such as claims processing, claims payment, membership services and utilization review.
Treatment: The procession, coordination or management of healthcare related to services provided by healthcare providers, including coordinating or managing healthcare with Community Health Options, consultation between Community Health Options and healthcare providers relating to a Member, or the referral of a Member for healthcare to a healthcare provider.
Triple Aim: Care, Health, and Cost. Improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.
Unplanned Outage: Any event which was unplanned including, but not limited to, inclement weather, declaration of a state of emergency by federal or state authorities, acts of God, etc.
Urgent Care: Any covered health care service provided to a Member in a situation which requires care within 24 hours. Urgent care does not rise to the level of an emergency as it allows the Member and provider to consider alternative settings of care.
Use: The sharing, employment, application, utilization, examination, or analysis of Member health information within Community Health Options.
Utilization Management: A Medical Management process of reviewing Member/patient clinical information to determine if a requested medical service is medically necessary. Also known as Utilization Review.
Utilization Review Manager (URM): An organization or a functional department of an organization that provides evaluation services of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities.
Waste and Abuse: Incidents or practices that are inconsistent with legal, ethical, accepted, and sound business, fiscal or medical practices that result in unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes plan Member practices that result in unnecessary costs to a health program.

Acronyms

ACA: Affordable Care Act; health reform law enacted in March 2010
ACO: Accountable Care Organization
APC: Ambulatory Payment Classification
ASC: Ambulatory Surgical Center
CCM: Complex Case Management
CDC: Centers for Disease Control and Prevention
CLIA: Clinical Laboratory Improvement Amendments of 1988

CMI: Case Mix Index
CME: Continuing Medical Education
CMS: Center for Medicare and Medicaid Services
COB: Coordination of Benefits
CPT®: Physician's Current Procedural Terminology
DME: Durable Medical Equipment
DRG: Diagnostic Related Groups
EDI: Electronic Data Interchange
EHR: Electronic Health Record
EMR: Electronic Medical Record
EOP: Explanation of Payment
ERISA: Employee Retirement Security Income Act of 1974
FDA: Food and Drug Administration
FFS: Fee for Service
FY: Fiscal Year
HAC: Hospital Acquired Condition
HCPCS: Healthcare Common Procedure Coding System
HEDIS®: Health Plan Employer Data and Information Set
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act of 1996
HIPPS: Health Insurance Prospective Payment System
HMO: Health Maintenance Organization
ICD-10-CM: International Classification of Disease, 10th Edition – diagnosis
ICD-10-PCS: International Classification of Disease, 10th Edition – procedure
INR: International Normalized Ration
JC: Joint Commission (formerly known as JCAHO; Joint Commission on Accreditation of Healthcare Organizations
LOB: Line of Business
LOS: Length of Stay
MCE: Medical Care Evaluations
MDS: Minimum Data Set
NCQA: National Committee for Quality Assurance
NDC: National Drug Code
NOMNC: Notice of Medicare Non-Coverage
NPI: National Provider Identifier
OIG: Office of Inspector General
OPPS: Outpatient Prospective Payment System
PCF: Personal Care Facility
PCP: A Primary Care Provider

PMPM: Per Member Per Month
PNM: Provider Network Management
POA: Present on Admission
POS: Point of Service
PPO: Preferred Provider Organization
PRO: Peer Review Organization
QHI: Quality Health Indicators
QI: Quality Improvement
QIO: Quality Improvement Organization
RBRVS: Resource-Based Relative Value Scale
SCP: Specialty Care Provider
SNF: Skilled Nursing Facility
SPD: Summary Plan Document
TPA: Third-Party Administrator
UCR: Usual, Customary, Reasonable Charges
UM: Utilization Management
USPHTF: United States Preventive Health Task Force