UNIVERSITY COMMUNITY CARE PLAN
COMMUNITY FIRST

UNIVERSITY COMMUNITY CARE PLAN
PROVIDER MANUAL

PROVIDER SERVICES 210-358-6030

UniversityCommunityCarePlan.com

Serving Bexar County

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COMMUNITY FIRST
INSURANCE PLANS

Community First Insurance Plans, Inc.

University Community Care Plan Provider Manual

Member Services: 210-358-6400

Updated January 2026

Covering residents in Bexar County .

UniversityCommunityCarePlan.com

EXHIBITS

Exhibits referred to throughout this Provider Manual can be accessed by clicking the link below or by visiting UniversityCommunityCarePlan.com.

EXHIBIT	FORM NAME & LINK
Exhibit 1	Request for Continuity/Transition of Care Form
Exhibit 2	Provider Request for Member Transfer Form
Exhibit 3	Community First Prior Authorization List
Exhibit 4	University Community Care Plan Member ID Card
Exhibit 5	Texas Standard Prior Authorization Request Form for Health Care Services
Exhibit 6	Medical Record Review Tool
Exhibit 7	American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care
Exhibit 8	CDC Adult Preventive Care Recommendations
Exhibit 9	Consent to Use a Physician Assistant/Nurse Practitioner Form
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I. INTRODUCTION

Welcome to University Community Care Plan by Community First Insurance Plans, Inc.

University Community Care Plan (UCCP) at Community First is a managed care plan for Health Insurance Exchange (HIE) Members. Our objective is to ensure that Members access primary care services appropriately and receive services in the most cost-effective setting. Our network comprises physicians, allied and ancillary health care providers, hospitals, and other facilities selected to provide quality health care to our Members.

The primary care provider (PCP) is responsible for managing the overall medical care of patients and when appropriate coordinating referrals to specialists and inpatient/outpatient facilities. A PCP is a Community First Provider with one of the following specialties: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology (during pregnancy), or Pediatrics.

This Provider Manual was written to assist you and your staff in working with us to deliver quality health care to Community First UCCP Members. It provides information regarding our utilization and quality management programs, preauthorization, referral notification procedures, filing of claims, and our complaint and appeals process.

We encourage you and your staff to review this Manual carefully and contact your Provider Relations Representative if you have any questions, comments, or concerns. We welcome Provider suggestions for enhancing this Manual and will be conducting semiannual provider surveys asking for your comments on the efficiency of training, communications programs, and any ideas for improvement.

THE ROLE OF THE PRIMARY CARE PROVIDER (PCP)

A primary care provider (PCP) is a Member's own doctor or health care clinic. The PCP is responsible for taking care of a Member's medical needs and acts as their main health care provider. If a Member needs to be admitted to the hospital, the PCP will also arrange the Member's care.

University Community Care Plan Members are not required to have a PCP.

A PCP can be a:

- Pediatrician
- Family or general practitioner
- Internist
- Obstetrician/gynecologist (OB/GYN)
- Nurse Practitioner (NP) or Physician Assistant (PA)

Members can choose a PCP from the University Community Care Plan Provider Directory at UniversityCommunityCarePlan.com or by logging into the Member Portal. Members can also call Member Services at **1-888-512-2347** for assistance.

PCPs provide preventive care:

1. To children under age 21 in accordance with the **American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (Exhibit 7).**

2. To adults in accordance with the **CDC Adult Preventive Care Recommendations (Exhibit 8).**

THE ROLE OF THE SPECIALTY CARE PROVIDER

The specialty care provider provides medically necessary services to UCCP Members for a specific disease or part of the body. There are many kinds of specialists.

A Member's primary care provider can help the Member find a specialist, but Members do not need a referral in order to make an appointment. Members can find a list of in-network specialists in the University Community Care Plan Provider Directory located at UniversityCommunityCarePlan.com or call Member Services at **1-888-512-2347** for assistance.

MEMBERS WITH DISABILITIES AND/OR CHRONIC/COMPLEX CONDITIONS

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

If the decision for Continuity of Care coverage is appropriate, the Medical Director will include instructions to Network Management to obtain a written agreement from the specialist that he or she is willing to accept responsibility for coordination of all the Member's health care needs. If the specialist is not willing to serve as the PCP, the request cannot be approved under the Continuity of Care policy.

Community First will approve or deny the request for Continuity of Care and provide written notification of the decision to the Member no later than thirty (30) days after receiving the request. If the request is denied, Community First will outline, via the written notification to the Member, the reasons for the denial of the request and the mechanisms to initiate an appeal.

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

1. Certification by the non-primary care provider specialist as a PCP.
2. A signed statement by the non-primary care provider specialist that they are willing to accept responsibility for the coordination of all the Member's health care needs, including referrals to other specialists.
3. The signature of the Member concurring with the request.

LIMITED PROVIDER NETWORKS

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

PROVIDER OFFICE RELOCATIONS

If a Provider relocates offices or expands to additional offices, the Provider should notify Community First within ten (10) business days and should not render services to Members until Community First has completed site visits for the new office location.

II. LEGAL AND REGULATORY

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

LAW, RULES, AND REGULATIONS

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

1. Environmental protection laws:
   a. Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
   b. National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
   c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
   d. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
   e. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;
2. State and federal anti-discrimination laws:
   a. Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
   b. Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
   c. Americans with Disabilities Act of 1990 (Public Law 101-336); and
   d. Title 40, Texas Administrative Code, Chapter 73.
3. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.) and the Immigration Act of 1990 (8 U.S.C. §1101, et seq.) regarding employment verification and retention of verification forms; and
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).

LIABILITY

1. In the event Community First becomes insolvent or ceases operations, the Provider understands and agrees that their sole recourse against Community First will be through Community First's bankruptcy, conservatorship, or receivership estate.
2. The Provider understands and agrees that Community First Members may not be held liable for Community First's debts in the event of the entity's insolvency.

MARKETING

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

MEDICAL CONSENT REQUIREMENTS

Providers must comply with medical consent requirements listed in Texas Family Code §266.004, which require the Member's or designation of a Legally Authorized Representative (LAR) medical consent for the provision of medical care.

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

MEMBER COMMUNICATIONS

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

PROVIDER RESPONSIBILITIES

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

PROFESSIONAL CONDUCT

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

1. Comply with applicable state laws, rules, and regulations and Community First's requests regarding personal and professional conduct generally applicable to the service locations; and
2. Otherwise conduct themselves in a businesslike and professional manner.

CONTRACT TERMINATION

Community First must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider, including a Straight-Through Process (STP). At least sixty (60) days before the effective date of the proposed termination of the Provider's contract, Community First must provide a written explanation to the Provider of the reasons for termination. Community First may

immediately terminate a Provider contract if the Provider presents imminent harm to patient health, actions against a license or practice, fraud, or malfeasance.

Within sixty (60) days of the termination notice date, a Provider may request a review of Community First's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a practitioner/provider license, or in credible cases of fraud or malfeasance. The advisory review panel will be composed of practitioners and Providers, as defined in §843.306 of the Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty. The decision of the advisory review panel must be considered by Community First but is not binding on Community First. The practitioner/provider is notified of the decision, and the health plan program participation status impacted, by certified mail within five (5) calendar days.

GIFTS OR GRATUITIES

A Provider may not offer or give anything of value to an employee of Community First in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the Provider contract at any time for violation of this requirement.

THIRD PARTY RECOVERY

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

TUBERCULOSIS

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

WOMEN, INFANTS AND CHILDREN (WIC)

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

III. CONTACT INFORMATION

Listed below are important telephone numbers for your reference.

CONTACT	PHONE NUMBER
UCCP Member Services (including Member eligibility/benefits and interpreter services)	1-888-512-2347 (toll-free) 210-358-6400 (local)
Population Health Management	210-358-6050
Preauthorization/Referral Notification Fax	210-358-6040
Case Management	210-358-6100 (option 3)
Urgent Care	210-227-2347
24/7 Behavioral Health & Substance Abuse Hotline	1-877-221-2226
TTY (For the Deaf and Hard of Hearing)	1-800-390-1175 or 711
Provider Relations (General Inquiries)	210-358-6294
Provider Relations (Claims Assistance)	210-358-6030

Interpreter Services
Interpreter and translation services are available to Members 24 hours a day, seven days a week, at no cost. Utilizing these services promotes Member safety and is mandated by regulatory agencies and/or contractual requirements. **Friends and/or family members should not be used as interpreters.**

Language assistance should be arranged through the Community First Member Services Department. Phone and on-site interpreters are available in over 200 languages by request. On-site interpreter requests require a 24-hour notice.

To arrange language assistance through the Member Services Department, please use the following contact information:

- STAR Members call 210-358-6060, toll-free 1-800-434-2347
- STAR Kids Member call 210-358-6403, toll-free 1-855-607-7827
- CHIP Members call 210-358-6300, toll-free 1-800-434-2347
- Medicare Advantage Alamo Plan (HMO) & Medicare Advantage Dual Special Needs Plan (DSNP HMO) Members call 210-358-6386, toll-free 1-833-434-2347
- University Community Care Plan (HIE) Members call 210-358-6400, toll-free 1-888-512-2347
- University Family Care Plan & Commercial Members call 210-358-6090, toll-free 1-800-434-2347

Website
Visit our website, UniversityCommunityCarePlan.com, for quick access to pertinent information and downloadable documents such as the plan's Preferred Drug List and **Community First Prior Authorization List (Exhibit 3).**

IV. MEMBER INFORMATION

VERIFYING ELIGIBILITY AND BENEFITS

Each Community First UCCP Member is issued a health plan identification card and is instructed to present their ID card when requesting medical services. The Member ID card indicates pertinent Member information including Member name, Member ID number, plan name, group number, policy effective date, and pharmacy information.

When new Members are enrolled into the plan, they are given the opportunity to choose a primary care provider (PCP) from amongst those accepting new patients.

Please Note: UCCP Members are not required to have a PCP.

At the time of the visit, ask the Member to show their Member ID card or their Community First enrollment form. (New Members may present a copy of their enrollment form as proof of coverage during the first thirty (30) days of their enrollment in the plan.) However, the Member ID card or enrollment form does not guarantee eligibility for coverage. Whether a Member presents their Member ID card or an enrollment form, Providers are encouraged to verify eligibility by calling Member Services and/or by logging into the Community First Provider Portal.

Verifying eligibility before rendering services is very important.

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

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

Listed below are helpful ways to verify eligibility:

1. Call the plan eligibility line at **210-358-6400** or **1-888-512-2347** and press "2."
2. Login to the Community First Provider Portal
3. Consult the monthly Member eligibility report (PCPs only)

If a Member has questions about benefit coverage or wants to change their PCP, please ask the Member to call Member Services at **210-358-6400** or login to the Member Portal by visiting UniversityCommunityCarePlan.com.

COPAYMENTS, DEDUCTIBLES, & COINSURANCE

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

SPAN OF ELIGIBILITY

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

- **Inpatient admissions prior to enrollment with Community First.** Community First is responsible for physician and non-hospital services from the date of enrollment with Community First provided Community First is notified of the admission by the Member or the Member's Provider. Community First is not responsible for any hospital charges for Members admitted prior to enrollment with Community First.
- **Inpatient admissions after enrollment with Community First.** Community First is responsible for authorized, covered services until the hospital discharges the Member, unless the Member loses eligibility.
- **Psychiatric Care.** Inpatient psychiatric care for Members in a freestanding psychiatric facility is Community First's responsibility from the Member's date of enrollment with Community First.

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

DISENROLLMENT

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

Community First has the right to request disenrollment of Members from the health plan. The Member may request the right to appeal this decision. The PCP will be responsible for directing the Member's care until the disenrollment is made.

A request to disenroll a Community First Member **is acceptable** under the following circumstances:

- Member misuses or lends their Community First Member ID card to another person to obtain services.
- The Member is disruptive, unruly, threatening, or uncooperative to the extent that the Member seriously impairs Community First's or a Provider's ability to provide services to the Member. This only applies, however, if the Member's behavior is not due to a physical or behavioral health condition.
- The Member steadfastly refuses to comply with managed care, such as repeated emergency department use combined with refusal to allow Community First to arrange for the treatment of an underlying medical condition.

PCP REQUEST FOR MEMBER TRANSFER

The PCP must submit a written request to Community First in order to transfer a Community First Member from the PCP's practice using Community First's **Provider Request for Member Transfer Form** (Exhibit 2)**.** If you have any questions regarding this process, please contact Provider Relations at **210-358-6294**.

MEMBER PCP CHANGE

If a Member requests a PCP change, the change will become effective immediately.

PRE-EXISTING CONDITIONS

The Provider is responsible for arranging for the provision of all covered services to each eligible Community First Member beginning on the Member's date of enrollment. All arrangements for covered services will be in accordance with contractual requirements between Community First and the Provider and with all applicable laws, rules, and regulations.

CONTINUITY OF CARE

Community First provides Members with timely and adequate access to out-of-network services as long as those services are medically necessary and/or not available within the network. If services become available from a network Provider, Community First is not obligated to provide a Member with access to out-of-network services. If Community First determines that disrupting a Member's existing relationship with an out-of-network provider would subject the Member to unnecessary psychological or medical risk, Community First may provide the Member access to those out-of-network services through an appropriate Letter of Agreement (LOA) with the out-of-network provider.

Continuity of Care coverage can be approved for special circumstances for which discontinuing or a break in service could potentially jeopardize the Member's condition, including:

- Transition of Care
- Specialty Care Provider as a PCP

Transition of care involves an active course of treatment rendered by a non-participating specialist that is expected to continue for ninety (90) days following the Member's effective date with Community First. An "active course of treatment" is one in which discontinuity would cause a recurrence or worsening of the conditions under treatment and interfere with anticipated outcomes (i.e., post-acute surgical care, fracture repair, prenatal care in the third trimester, illness recovery, chemo/radiation treatment, psychotherapy for an acute exacerbation, or chronic psychiatric condition).

A specialty care provider as a PCP is designed to provide for the complex care needs of Members who have either disabilities or chronic/complex medical or behavioral conditions. Through collaboration with Community First Nurse Case Managers, Members with disabilities or chronic/complex medical or behavioral conditions are encouraged to maintain a stable "medical home" (PCP), with unduplicated services through the appropriate development of a care plan.

In certain qualifying situations, Community First may allow a participating specialist currently treating a Member with disabilities or chronic/complex conditions to serve in the capacity of the PCP, using the criteria set forth in Chapter I of this Manual.

PCPs and specialists can call our Population Health Management Department at **210-358-6050** to address any continuity of care issues.

RELEASE OF INFORMATION

A Provider can obtain a signed authorization for release of information from Community First Members. This will enable Community First to process claims and perform our utilization management and quality management functions.

MEMBER PRIVACY

As of April 14, 2003, Community First and all Providers in the Community First network are required to comply with federal regulations adopted under the Health Insurance Portability and Availability Act of 1996 governing the privacy of individually identifiable health information. Though Senate Bill 11 passed during the 77th Legislative Session, Texas also substantially incorporated HIPAA privacy regulations into Texas law, giving the state its own enforcement powers. Community First is enacting policies and processes to meet the compliance deadline and anticipates that the Providers in its network are also taking steps to ensure compliance.

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

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

PROTECTED HEALTH INFORMATION

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

PCP REQUEST TO CHANGE PANEL STATUS

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

Please Note: According to your agreement with Community First, you must notify Community First in writing at least sixty (60) days prior to any action by you to limit or close your panel to Community First UCCP Members. Notifications less than sixty (60) days to limit or close your panel will be considered on a case-by-case basis.

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

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

- You have the right to receive information about your health plan, its services, its practitioners and providers, and your rights and responsibilities.
- You have the right to be treated with respect, dignity, privacy, confidentiality, and nondiscrimination.
- You have the right to participate with providers in making decisions about your health care.

- You have the right to an open, honest discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to use the complaints or appeals process through Community First and get a timely response to complaints and appeals about your health plan or the care it provides.

MEMBER RESPONSIBILITIES

- You have the responsibility to learn and understand your rights and ask for help when you need it.
- You have the responsibility to follow all Community First rules and policies.
- You have the responsibility to treat all doctors and health care providers with respect and courtesy.
- If you do not understand the type of care you are receiving or what is expected from you as part of a treatment plan, you have the responsibility to inform your providers and ask for help.
- You have the responsibility to share information about your health with your providers so you can work as a team to decide what health care is best for you.
- You have the responsibility to participate in creating a treatment plan with your provider and follow plans and instructions for care that you've agreed upon.
- You have the responsibility to inform Community First of any changes to your personal information, including your name, address, or family members covered under your plan.

IDENTIFYING MEMBERS

Each Member is issued a **Community First University Community Care Plan Member ID Card (Exhibit 4)**. Members are instructed to present their Member ID card when requesting services. The Member ID card includes important Member information and Community First telephone numbers.

BILLING MEMBERS

By entering into an agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services you render to Members.

Please Note: This means that you may not bill Members for the difference between your normal charges and the contracted rate with Community First for rendering covered services.

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

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

- Failure to submit a claim to Community First for initial processing within ninety-five (95) days from the date of service (DOS).

- Failure to submit a corrected claim within the ninety (90) day filing re-submission period.
- Failure to appeal a claim within the thirty (30) day appeal period.

MEMBER ACKNOWLEDGMENT STATEMENT

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

A Provider may bill the Member for a non-covered service if both of the following conditions are met:

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

FAMILY PLANNING

Community First requires that any Members requesting contraceptive services or family planning services are also provided counseling and education about available family planning and family planning services at healthytexaswomen.org.

Providers cannot require parental consent for Members who are minors to receive family planning services.

Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

ADVANCE DIRECTIVES

Providers must comply with the requirements of state and federal laws, rules, and regulations related to advance directives available at hhs.texas.gov/formas/advance-directives.

AUDIT OR INVESTIGATION

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

1. Community First Insurance Plans
2. U.S. Department of Health and Human Services
3. Office of Inspector General (OIG); Texas Health and Human Services Commission (HHSC), Centers for Medicare & Medicaid Services (CMS), or TDI
4. An independent verification and validation contractor or quality assurance contractor
5. State or federal law enforcement agency
6. Special or general investigation committee of the Texas Legislature

7. The U.S. Comptroller General
8. The office of the State Auditor of Texas
9. Any other state or federal entity identified by Community First

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

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

1. Examination
2. Audit
3. Investigation
4. Contract administration
5. The making of copies, excerpts, or transcripts
6. Any other purpose Community First deems necessary for contract enforcement or to perform its regulatory functions

V. UTILIZATION MANAGEMENT

OVERVIEW

The Utilization Management Program (UMP) plan of Community First describes and delineates a comprehensive, ongoing Utilization Management (UM) methodology. The plan's purpose is to provide a template for Community First staff and to provide guidance to physicians and other health care providers in the management and oversight of UM activities. The plan's goal is to assure that quality medical, behavioral health, and substance abuse care and services are provided to our Members in a cost-efficient manner and to identify potential quality of care or service issues.

The scope of the UMP encompasses the range of processes utilized to determine the efficacy and efficiency of patient-centered medical, behavioral health, and substance abuse services. The UMP includes formal preauthorization, concurrent review, discharge planning, Case Management, Service Coordination, and retrospective review and provides an appeal process to address disputes in a timely manner (see Chapter IX. Billing and Claims Administration). Current clinically valid approval criteria and information sources, trended data, patterns of utilization, and patient outcomes are consistently used to standardize these processes and reduce reviewer subjectivity.

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

All reimbursement is subject to eligibility and contractual provisions and limitations. Successful operation of our utilization management program depends upon your cooperation by:

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

PREAUTHORIZATION

The PCP is responsible for initiating all referrals to non-participating providers. (For more information about referrals, please refer to Chapter V, Section C of this Provider Manual.)

Please Note: Community First must give preauthorization before any Member's admission to a facility or visit a non-participating provider. Failure to obtain preauthorization in advance of the service being rendered will result in an administrative denial of the claim and Providers cannot bill Members for covered services.

Community First utilizes the term "pre-service authorization" when referring to all types of service that require approval prior to provision. Pre-service review allows for benefit determination, the evaluation of proposed treatment, determination of medical necessity or appropriateness, determination on whether the requested service is considered experimental or investigational, level of care assessment, an assignment of length of confinement, and appropriate placement prior to the delivery of service.

Community First requires pre-service authorization for all of the services outlined in the current **Community First Prior Authorization List (**Exhibit 3**).** This authorization list can also be accessed by logging into the Provider Portal and is subject to change. Community First will provide at least sixty (60) days' notice of changes to the authorization list.

Community First makes Utilization Management decisions for behavioral, pharmaceutical, and medical services in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption or delay in the provision of health care.

Pre-service authorizations are routinely valid for thirty (30) days from the date issued and usually do not exceed ninety (90) days unless a longer time frame is prearranged.

Requesting Providers may fax a completed **Texas Standard Prior Authorization Request Form for Health Care Services (Exhibit 5)** to Population Health Management at **210-358-6040**. This form is also available and can be submitted via the Provider Portal.

Please ensure the following information is included when submitting for preauthorization:

- Member's name and ID number.
- Primary diagnosis with ICD-10 code.
- Surgery and diagnostic procedure, or purpose of request, number of visits, and frequency.
- All pertinent clinical information, test results, office notes (for genetic testing, include LOMN).
- Anticipated date of service or admission date.
- Name of Provider/facility requesting or providing the services.
- Expected length of stay (inpatient only).

Population Health Management will issue an authorization number for approved requests. Notifications are mailed to the Member and faxed to the Provider. Life threatening urgent telephone requests will receive an authorization telephonically.

If a request is pended because information is incomplete or received without clinical documentation (i.e., progress notes, lab values, etc.) on the Provider's orders, an attempt will be made to notify the Provider. Once we receive the required information, we will either approve the request or send the information to the Community First Medical Director for final review. If we do not receive the required information, the requested services will be subject to administrative denial for lack of requested information.

We will deny requests for services that are not covered or do not meet the Member's benefit criteria. Community First will notify the Provider verbally via phone and letters are sent via fax within seventy-two (72) hours of the determination.

Prior to any adverse benefit determination (denial based on medical necessity, appropriateness, or the experimental or investigational nature of a health care service), Community First affords the requesting Provider the opportunity to discuss the plan of treatment for the Member and the clinical basis for the utilization decision with a Medical Director.

Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If the pre-service authorization expires, call Population Health Management and resubmit another request via fax or through the Provider Portal.

Appropriate Population Health Management personnel are available to respond to UM inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday and allows response to telephone requests by a toll-free telephone that can accept utilization review inquiries outside of these hours.

REFERRALS

The PCP or specialist may directly refer a Member for services that do not require preauthorization. All referrals must be to a UCCP network Provider. A current Provider Directory is located at UniversityCommunityCarePlan.com, on the Provider Portal or Providers may contact Provider Relations at **210-358-6294** for further Provider information.

Use of a non-participating provider requires preauthorization by Community First. Specialists must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Community First requires preauthorization for court-mandated inpatient psychiatric care for all Members, regardless of age.

Please Note: Payment for services requiring authorization is contingent upon verification of current eligibility and applicable contract specifications at the time of service. For verification of eligibility, please call **1-888-512-2347**.

SELF-REFERRALS

Members may self-refer for the following services:

- Emergency care
- Obstetrical and/or gynecological services
- Routine vision for in-network vision providers only (call Member Services to verify benefits and in-network Providers)
- Behavioral health

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

URGENT CARE

An urgent care situation is not as serious as an emergency. Urgent care includes services other than those for an emergency that result from an acute injury or illness that is severe or painful enough to lead a person with an average knowledge of medicine and health to believe that the condition, illness, or injury is such that failure to get treatment within a reasonable period of time would cause serious deterioration of his or her health.

For urgent medical care, the Member should call their PCP's office, even on nights and weekends. The PCP or a doctor on call will tell the Member what to do.

The Member will need to go to an in-network urgent care clinic that accepts University Community Care Plan. Community First has arrangements with in-network clinics that accept the University Community Care Plan and are listed in the Provider Directory.

EMERGENCY CARE

Community First should be notified of emergency admissions, transportations, or procedures within twenty-four (24) hours.

Only emergency care services are covered outside of the plan's service area.

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

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

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

If the Member has received emergency care and the Provider who treated the Member indicates that the Member will need follow-up care to complete the treatment, the follow-up care must be rendered by the participant's PCP or the appropriate specialist, not by the Provider who treated the Member for the medical emergency. The participant, or someone acting on the participant's behalf, should contact the participant's PCP or the appropriate specialist within twenty-four (24) hours, or as soon as reasonably possible, so that he or she may arrange for follow-up care.

BEHAVIORAL HEALTH SERVICES

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

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

Community First's Case Management staff is available to assist you in identifying and accessing network behavioral health providers on behalf of your patients. We encourage

you to call Population Health Management at **210-358-6050** with any questions regarding behavioral health services.

Definitions
Behavioral health services are covered services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

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

When assessing Members for behavioral health services, Providers must use the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-V) tool and reference guide to diagnose, classify, and identify mental health conditions. Community First may require use of other assessment instruments/outcome measures in addition to the DSM-V. Providers must document DSM-V and assessment/outcome information in the Member's medical record.

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

Behavioral Health Services
Depending on the Member's benefit plan, behavioral health services may include the following:

- **Outpatient Services:** Individual, family, group counseling/therapy, and medication management provided by a network behavioral health practitioner.
- **Inpatient/Acute Care:** A highly structured 24-hour program in which a psychiatrist directs the Member's care.
- **Partial Hospitalization Program (PHP):** A highly structured program used as an alternative to acute inpatient admission, usually a day program that may include educational services.
- **Intensive Outpatient Treatment/Day Treatment (IOP):** A highly structured program used as a prevention, alternative, or transition from acute inpatient hospitalization and/or partial hospitalization; can be a day, evening, or weekend program.
- **Off-Site Services:** Services provided to help reduce or avoid inpatient admissions (i.e., home-based services, school-based services, and mobile crisis services).
- **Residential Services:** A 24-hour-a-day program that is not inpatient hospitalization (i.e., crisis stabilization, short-term respite, residential treatment, respite residential, group homes).
- **Other Services:** Other services may be available if medically indicated.

The behavioral health provider must verify the benefits for which the Member is eligible. Please call Member Services at **1-888-512-2347.** It is critical that verification of eligibility and benefits be performed and re-verified during treatment.

Behavioral Health Documentation Requirements
Providers must document the following for Community First:

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

Member Assessment and Referral
A Member can access behavioral health services by:

- Self-referral to any network behavioral health provider;
- Calling Community First at **1-888-512-2347** and obtaining the names of network behavioral health providers.

Community First does not require that Members have a PCP referral to obtain an initial consultation visit with a network behavioral health provider.

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

Consultation regarding the appropriateness of the level of care is available through Community First's Case Management staff. Case Managers are available to receive calls seven days a week, 24 hours a day, including holidays.

A psychiatric consultation is required for the following:

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

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

Consent for Disclosure of Information
A written medical record release must be obtained from the Member, or a parent or legal guardian of the Member, before the Provider can send the Member's behavioral health report to the PCP. The Member will be advised that they are not required to sign the

release and treatment will not be denied if the Member objects to signing the form. The Provider will place a copy of the signed release in the Member's record.

Litigation
Behavioral health providers agree to testify in court as needed for child protection litigation.

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

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

Rescheduling Behavioral Health Appointments
Community First requires that all Providers contact Members if the Member misses a scheduled appointment and reschedule such appointment within twenty-four (24) hours of the missed appointment.

Quality Management Improvement Program/Behavioral Health Medical Records
Our Quality Management and Improvement Program (QMIP) is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the health care delivery system. Components of this program include problem-focused studies, peer review, risk management, medical record review, ongoing monitoring of key indicators, and behavioral health care services evaluation.

The success of the QMIP depends upon your cooperation by:

1. Providing medical records concerning our Members upon request;
2. Maintaining the confidentiality of Member information;
3. Promptly responding to phone calls or letters concerning Quality Management issues;
4. Cooperating with Quality Improvement Committee proceedings;
5. Participating in the Quality Improvement Committee, Credentials Committee, Utilization Management or Pharmacy and Therapeutics Committee, if appropriate.

These committees consist of network Providers who are board certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Provider Relations Representative.

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

1. Accepting and returning our phone calls concerning our Members;
2. Allowing us to review medical and financial records concerning care rendered to our Members;

3. Participating with us in discharge planning, disease management, and case management;
4. Participating with our Community First committee proceedings when appropriate.

VI. CASE MANAGEMENT AND DISEASE MANAGEMENT SERVICES

Community First Case Management applies to all lines of business, and efforts primarily focus on high-risk, high-utilizing Members.

Community First Case Management is a key component of Community First's Population Health Management Strategy. Case Management provides comprehensive, person-centric services and goal setting for Members who have complex medical needs and require a wide variety of resources to manage their health and improve their quality of life. Case Management emphasizes the importance of communication between PCPs, specialists, and Community First.

Community First embraces a holistic approach to managing quality of life by treating every Member as a whole. Within this holistic approach, our interdisciplinary team relies on experienced professionals from diverse backgrounds including social work, nursing, mental health, home care, and home health. Although we work as a team, our Case Managers serve as the primary point of contact and collaborate with the Member, their family members, and all relevant service providers.

Our Case Managers are trained Registered Nurses or social workers who work closely with the Member, their family, their primary care provider (PCP), or other health care providers, to help the Member understand their condition and how to better take care of themselves. The team will also provide the Member with resources that can help them get the best care possible utilizing the right providers, in the right setting, and in the right time frame.

Community First's Case Management services include Complex Case Management, Case Coordination, and Service Management.

Complex Case Management
Complex Case Management includes:

- Systematic assessment of the patient's medical, functional, and psychosocial needs.
- System-based approaches to ensure timely receipt of all recommended preventive care services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patients' self-management of medications.
- Coordinating care with home- and community-based clinical service providers.

Care Coordination
Care Coordination is an essential, ongoing sub-component of Case Management. Providers working with a particular Member will share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep Members and their families informed and ensure that effective referrals and transitions occur. Provided services can include oversight of transitions between and among health care providers and settings, including referrals to other clinicians, and follow-up after an emergency department visit or facility discharge.

Service Coordination
Community First performs Service Coordination for Members with Special Health Care Needs (MSHCN) to facilitate development of a service plan and coordination of

services among a Member's Primary Care Provider (PCP), specialty providers, and non-medical providers to ensure MSHCN have access to, and appropriately utilize, medically necessary covered services, non-capitated services, and other services and supports.

Community First's Case Management team is committed to working with Members, their family, doctors, and other members of their health care team, to improve the Member's overall health and to obtain the services they need.

If you would like to refer a Member who would benefit from Case Management, please make a referral by emailing the Case Management referral form located on the Provider Portal to help@cfhp.com. A Case Manager will contact the Member to discuss their individual health care needs.

If you want to learn more about Case Management services, please call Population Health Management at **210-358-6050**.

VII. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

INTRODUCTION

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

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

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

GENERAL REQUIREMENTS OF THE COMMUNITY FIRST QMIP

The success of the Community First QMIP depends upon your cooperation by:

- Providing medical records concerning our Members upon request;
- Maintaining the confidentiality of Member information;
- Promptly responding to phone calls or letters concerning Quality Management issues;
- Cooperating with the Quality Improvement Committee proceedings; and
- Participating on the Quality Improvement Committee, Credentialing Committee, Utilization Management, or Pharmacy and Therapeutics Committee, if appropriate.

These committees consist of in-network Providers who are board certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Provider Relations Representative.

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

CREDENTIALING AND RECREDENTIALING

For participation, all individual practitioners must complete the Texas Standardized Credentialing Application (TSCA).

- Practitioners undergo a careful review of their qualifications, including education and training, licensure status, board certification, work history, and malpractice history.
- Practitioners have the right to review information submitted in support of their credentialing application, with the exceptions of recommendations or other information that is peer protected.
- Practitioners have the right to correct conflicting or erroneous information regarding the application within fourteen (14) business days of written communication from Community First.

Practitioners who meet the criteria and standards of Community First are presented to the Medical Director for final approval of their credentials. Practitioners who do not meet the criteria and standards of Community First are presented to the Credentialing Committee for review. Community First will not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

Credentialing is required for all practitioners and Providers who are listed in the University Community Care Plan Provider Directory Practitioners or providers who are members of a contracted group, such as an independent physician association or medical group, are credentialed individually. Credentialing is not required for hospital-based physicians or for practitioners/providers who will not be listed in the Provider Directory.

Recredentialing is performed at least every three (3) years. In addition to the verification of current license, DEA certificate, malpractice insurance, National Practitioner Data Bank query, and sanction activity by Medicare and Medicaid, the process will also include review of Member complaints and information from quality improvement activities.

LIABILITY INSURANCE

During the term of the Provider contract, a Provider shall maintain Professional Liability Insurance of $100,000 per occurrence and $300,000 in the aggregate, or the limits required by the hospital at which a network Provider has admitting privileges.

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

NATIONAL PROVIDER IDENTIFIER

All Providers must have a National Provider Identifier (NPI).

FACILITY REVIEWS

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

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

Should the site not conform to Community First's standards, a corrective action plan shall be requested, and a follow-up visit shall be conducted every six (6) months until the site complies with the standards.

Community First may conduct a site visit to the office of any physician or Provider at any time for cause. The site visit to evaluate the complaint or other precipitating event

will be conducted by the appropriate personnel. It may include, but not be limited to, an evaluation of any facilities or services relating to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

MEDICAL RECORD REVIEWS

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

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

Reviews are conducted assessing performance against Community First medical records and preventive standards. Those practitioners with scores below the established threshold of 80 percent in one or more domains will be required to adopt a Corrective Action Plan. Follow-up reviews will be performed within ninety (90) to one hundred eighty (180) days of the prior review to assess those areas identified that need action or process changes. If process improvements are not implemented within the specified time frame, it may be a breach of contract and may result in termination from the practitioner network.

Facility/Medical Record Review Procedure

Community First Insurance Plans nurses will:

1. Schedule an appointment, in advance, to conduct the facility and/or medical record review. In most cases, the medical record review can occur at the same time as the facility site review.
2. Provide the audit tools and standards to the practitioner's office prior to the review, if requested.
3. Conduct the review according to Community First standards and document findings within approved data collection tools. A minimum of three (3) medical records per product type (i.e., Commercial, CHIP and Medicaid, HIE) per Provider are reviewed.
4. Following the visit, provide a verbal summary of the findings to the practitioner or their designee.
5. Send a letter notifying the practitioner of the findings and requesting a corrective action plan if needed.

6. Perform follow-up reviews with offices that are non-compliant to ensure corrective actions are in place.
7. If the non-compliance is not corrected, forward the results to the Chief Medical Officer or designee and/or the Quality Improvement Committee for review and interventions.

Inability to meet a threshold in two (2) consecutive reviews results in a referral to Peer Review by the Quality Improvement Committee (QIC). Providers should perform interventions as directed.

1. Prepare an annual report for the QIC identifying the number and types of reviews performed.
2. Aggregate data of all medical record audits performed during the year and analyze outcome data to assess opportunities for improvement and report findings to the QIC.

Links to the following materials are included in this Manual for review:

- **Medical Record Review Tool (Exhibit 6)**
- **American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (Exhibit 7)**
- **CDC Adult Preventive Care Recommendations (Exhibit 8)**

PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

Community First requires practitioners who employ Physician Assistants, Advanced Practice Nurses, and individuals other than physicians to assess the health care needs of Community First Members to have written policies which are implemented and enforced and describe the duties of all delegation, collaboration, and supervision as appropriate.

It is preferred that practitioners obtain the Member's consent when seeking services from a Physician Assistant or Advanced Practice Nurse using the **Consent to Use a Physician Assistant/Nurse Practitioner Form (Exhibit 9).**

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

1. Be licensed by the Texas State Board of Nurse Examiners or other state licensing authority;
2. Be recognized by the licensing authority as an Advanced Nurse Practitioner;
3. Comply with all applicable federal and state laws and regulations governing the services provided;
4. Be enrolled and approved for participation with Community First;
5. Comply with the terms of the Provider agreement, including regulations, rules, handbooks, standards, and guidelines published by Community First; and
6. Bill for services covered by Community First in the manner and format required by the Community First Claims Administration Program.

Subject to the specifications, conditions, requirements, and limitations established by Community First, services performed by Advanced Nurse Practitioners are covered if the services:

1. Are within the scope of practice for Advanced Nurse Practitioners, as defined by state law;

2. Are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate licensing authority; and
3. Would be covered by Community First if provided by a licensed physician (MD or DO).

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

PRACTICE GUIDELINE DEVELOPMENT

In an effort to provide and maintain quality health care and preventive services, Community First has established a process for evaluating patterns of care for specific conditions and procedures. Compliance with the guidelines is evaluated during the medical record review process.

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

The Quality Improvement Committee has also approved Clinical Practice Guidelines for acute and chronic medical illnesses that are adopted using national standards and are current and evidence-based. Examples of such guidelines include asthma, prenatal care, depression, and attention-deficit/hyperactivity disorder. Selected measures are measured annually, and quality improvement activities are implemented as appropriate.

CONFIDENTIALITY

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

CONFLICT OF INTEREST

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

NETWORK PROVIDER AVAILABILITY AND ACCESSIBILITY STANDARDS

The purpose of these guidelines is to ensure that health services are available and accessible to Community First Members. Because Community First contracts with a closed panel of practitioners, it is essential that we have a sufficient number of practitioners in our network who are conveniently located to serve our enrollees. By monitoring compliance with these guidelines, Community First can identify opportunities to improve our performance, and to develop and implement intervention strategies to affect any necessary improvement.

Community First has primary care providers (PCPs) available throughout the service area to ensure that no Member must travel more than 30 miles, or 45 minutes, whichever is less, to access the PCP.

Community First network Providers must be available to Members by telephone 24 hours a day, seven days a week for consultation and/or management of medical concerns.

Network Provider Availability Standards

Participating PCPs (or their designated physician coverage) and referral specialists are to be available and accessible to Members 24 hours per day, seven days per week within the Community First service area. Telephone access to PCPs (or their designated physician coverage) must be available at all times.

The following are acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

Acceptable:

a. Office phone is answered after hours by an answering service that meets the language requirements of the major population groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
b. Office phone is answered after regular business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP or another network Provider designated by the PCP. Someone must be available to answer the designated network Provider's phone. Another recording is not acceptable.
c. Office phone is transferred after hours to another location where someone will answer the phone and can contact the PCP or another designated network Provider.

Unacceptable:

a. The office phone is only answered during office hours.
b. The office phone is answered after hours by a recording which tells patients to leave a message.
c. The office phone is answered after hours by a recording that directs patients to go to an emergency department for any services needed.

Network Provider Access Standards

NETWORK PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
Emergency Care, including Behavioral Health	24 hours a day, seven days a week, upon Member presentation at the delivery site, including non-network and out-of-area facilities
Urgent Care: (PCP) (Specialist) (Behavioral health)	Within 24 hours of request Within 24 hours of request Within 24 hours of request
Routine Care: (PCP) (Specialist) (Behavioral health)	Within 14 days of request Within 14 days of request Within 14 days of request
Routine/Scheduled Inpatient/Outpatient Care	Within 14 days of request
Behavioral Health Discharge Planning/ Aftercare	Members discharged from an impatient setting must have a scheduled follow-up outpatient appointment within 7 days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments.
Initial Outpatient Behavioral Health Visits	Within 14 days of request
Routine Specialty Care Referrals	Within 21 days of request
Physical Examinations	56 days or less (4 to 8 weeks)
Prenatal Care (Initial)	14 calendar days or less or by the 12th week of gestation. Members who express concern about termination will be addressed as Urgent Care.
High-risk pregnancies or new Members in the third trimester	Within 5 days or immediately if an emergency exists.
Well-Child Care: Routine Well-Child Care Routine Well-Adolescent Care	 Within 14 days of request Within 14 days of request
Well Child Exam	Within 14 days of request
Children of Traveling Farm Workers	Staff must ensure prompt delivery of services to children of traveling farm workers and other migrant populations who may transition into or out of an HMO program more rapidly and/or unpredictably than the general population.
Newborn Care (in a hospital)	Newborns must receive an initial newborn checkup before discharge from the hospital to include all required tests and immunizations.

NETWORK PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
Newborn Care (after discharge from a hospital)	Within 3 to 5 days after birth and then within 14 days of hospital discharge.
Preventive Health Services for Children and Adolescents	Within 14 days of request
Preventive Health Services for Adults	Within 90 days of request in accordance with U.S. Preventive Service Task Force recommendations.
Physical Therapy: (Routine) (Urgent) (Follow-up)	3 days or less Within 24 hours 14 days or less
Radiology: (Urgent) (MRI/CT Scan) (IVP/UGI) (Mammogram)	Within 24 hours 7 days or less 10 days or less 21 days or less
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within 2 hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection.
Provider Office Waiting Time	Within 30 minutes of scheduled appointment time.
Requests for Feedback from Pharmacy Related to Prescriptions	Within 24 business hours

Provider Updates to Contact Information

Network Providers must inform both Community First and TMHP of any changes to the Provider's address, telephone number, and/or group affiliation.

VIII. HEALTH PROMOTION & DISEASE MANAGEMENT

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

Provider Referral
Providers are encouraged to inform Members about the health education services available to them. When an education or social need is identified, a Provider can refer a Member to Preventive Health and Disease Management one of several ways:

- Mail the **Member Education Request Form (Exhibit 10)** to:
  Community First Health Plans
  Attn: Community First Insurance Plans Network Management
  12238 Silicon Drive, Suite 100
  San Antonio, TX 78249
- Fax the **Member Education Request Form (**Exhibit 10**)** to **210-358-6199**.
- Contact a Community First Health Educator at **210-358-6055**.
- Email a Community First Health Educator at healthyhelp@cfhp.com.

Community First New Member Assessment Program
Outreach is initiated to each new Member to detect health risk factors, potential participation in population-based initiatives or disease management programs, and to assess barriers to care. Educational information and resource information is given to Members, including social services resources. Common Member concerns include transportation, utilities, and nutritional resources.

Although not all social concerns are directly related to their medical care, frequently these issues affect access to care, continuity of care, and compliance with a treatment plan. Community First works to assist Members in addressing these concerns to promote overall wellness. Information gathered from the Member is forwarded to the primary care provider for review, potential outreach, and inclusion in the medical record.

Health Education Services
Health education is available through the Member's chosen method of contact via classes, educational mailouts, and individualized telephone outreach. Several initiatives have been developed to educate Members and promote involvement in self-care behaviors. Participation in disease management and health promotion initiatives is free-of-charge, and Members may opt out at any time.

Overall program goals include increased education regarding disease processes and management, establishment of a collaborative physician-patient relationship, appropriate utilization of health care resources, increased quality of life, and Member satisfaction and retention.

Program participation information is routinely mailed to the primary care provider for review and inclusion in the Member's medical record. When an education or social

need is identified, a Provider can refer a Member to the Health Promotion and Disease Management Program by contacting a Community First Health Educator at **210-358-6055** or by emailing healthyhelp@cfhp.com.

A complete list of Community First's Health and Wellness Programs can be found on our website at CommunityFirstHealthPlans.com/Health-and-Wellness-Programs.

HEALTHY EXPECTATIONS MATERNITY PROGRAM

The percentage of women seeking and obtaining prenatal care during the first trimester has increased. Many high-risk women, however, continue to have trouble accessing early prenatal care. This is a significant problem in south and central Texas and of considerable concern for pregnant teens in Bexar County.

Community First is committed to addressing these issues at large through our **Healthy Expectations Maternity Program** because of the opportunity for a "win-win" situation. Health outcomes are improved, and the cost of prenatal care is reduced. **Healthy Expectations** employs two phases to reach out and educate prenatal Members.

Access to early prenatal care is a hallmark of quality health care. Community First has worked with the Health and Human Services Commission and health plans across the state to expedite the Medicaid eligibility determination and the enrollment of pregnant women into Medicaid-managed care. As a result, Medicaid eligibility has been simplified and a process is in place to expedite enrollment within thirty (30) days of application. Health plans receive the names of newly enrolled Members daily to promote immediate access to prenatal care.

The Population Health Management staff collaborates with health plan providers to offer comprehensive perinatal services, as we believe education is an important factor in changing behaviors and improving the overall health of our Members. Outreach to pregnant Members includes:

- Completion of a prenatal health risk assessment,
- Referral to educational or community resources as needed,
- Education regarding the importance of early prenatal care,
- Assignment of a pediatrician prior to birth and newborn checkups, and
- Education regarding the importance of the six-week postpartum visit.

An assessment program for identified pregnant women provides an opportunity to identify risk factors. Social and behavioral health education and referral are typical outcome strategies in the initial assessment phase. When completed, the risk tool allows staff time to reach those at increased risk for complications. Those at lower risk are sent educational materials and encouraged to attend community-sponsored prenatal education classes. Pregnant Members who elect to enroll in the program are routinely reassessed at 20-24 weeks gestation to evaluate for changes in prenatal health.

The phases of the Healthy Expectations prenatal program provide numerous opportunities to assess Member health, pregnancy status, to promote compliance with appropriate perinatal guidelines, and provide Member education. Programs such as Healthy Expectations have been recognized by the American Association of Health Plans as best practices in Case Management for prenatal care.

DIABETES IN CONTROL: DIABETES MANAGEMENT PROGRAM

Per the CDC's National Diabetes Statistics Report of 2023, 38.4 million adults ages 18 and older in the United States have diabetes (11.6 percent of the U.S. population). More than 8.7 million of this population are undiagnosed (Overall, 22.8 percent of people with diabetes are undiagnosed). In Bexar County in 2019, one in eight adults had been diagnosed with diabetes.

Accessible to membership, Community First developed a diabetes disease management program, **Diabetes in Control: Diabetes Management Program,** to promote a collaborative approach to diabetes self-management. The goals of the program include the identification of Members with diabetes, increased awareness and understanding of diabetes, increased risk reduction behaviors, improved access to quality diabetes education and health care services, and promote diabetes standards of care, in coordination with the Texas Diabetes Council's Minimum Standards for Diabetes Care in Texas.

Members are identified via pharmacy management records, claims and encounter utilization data, physician referral, Case Management/Utilization Management, health promotion, Member Services referrals, and information gathered through self-reported Member health assessments. Case Managers screen Members for possible referral to Diabetes in Control by reviewing claims histories.

Members enrolled in **Diabetes in Control** receive ongoing information that includes how to control their blood sugar, tips for talking to their doctor, routine diabetes screening tests, the Member's role in preventing complications, blood sugar testing and supplies, and self-management during an illness. Members are also eligible to attend community-based diabetes education classes.

Higher-risk Members are referred to one-on-one intensive education, which provides education on the importance of regular checkups, checking blood sugar at home, exercising regularly, following a meal plan, taking necessary medication, maintaining recommended weight, taking care of skin and feet, and management of their diabetes in conjunction with other current acute or chronic conditions.

Because depression is a well-documented component of this chronic condition, potential behavioral health needs are also taken into consideration and incorporated into the plan of care.

ASTHMA MATTERS: ASTHMA MANAGEMENT PROGRAM

Asthma Matters: Asthma Management Program is an initiative developed by Community First to improve the health, well-being, and productivity of our Members with asthma. Through ongoing review and oversight of this comprehensive disease management program, Community First works to provide quality health promotion and education services in collaboration with our Members, Providers, and community organizations. A key element of the program is to promote the development of a strong collaborative relationship between our Members and their primary care providers and the use of nationally accepted care standards for asthma to help Members achieve long-term control of their disease, which will result in the appropriate utilization of health care services.

Asthma Matters targets Members identified as having asthma via pharmacy management records, claim and encounter utilization data, and information received via the completion of Member health surveys. Utilization patterns are routinely assessed and targeted interventions are implemented to coordinate health care delivery and measures to improve Members' clinical, quality of life, and economic status.

Clinical outcomes may include a decrease in the use of beta-agonists, an increase in use of asthma-controlling medications, and an increase in the number of outpatient visits. Improvement in quality-of-life factors may include increased productivity and activity without asthma episodes, decreased absences from work or school, sleeping through the night without asthma episodes, increased knowledge about the disease, and overall asthma control with a decrease in acute asthma episodes. Economic outcome measures include decreased hospital admissions and emergency department events and/or unscheduled visits.

Upon identification of prospective Members, steps are taken to assess asthma severity levels and implement appropriate education and outreach services for each Member. Prospective **Asthma Matters** participants are sent an asthma health risk appraisal form. Key areas assessed include current symptoms, treatment protocols, and perception of quality of life. Upon receipt of the survey, Members are stratified into one of three risk categories: low, moderate, and high risk. For each risk category, health promotion outreach activities include the following:

- **Low Risk:** Send education literature bimonthly.
- **Moderate Risk:** Send education literature quarterly; provide an age-appropriate peak flow meter, OptiChamber kit, and allergy-free pillow cover; and perform a follow-up call/recommendation for asthma class.
- **High Risk:** Send education literature quarterly; provide an age-appropriate peak flow meter, OptiChamber kit, and allergy-free pillow cover; refer to Case Management for further evaluation and/or possible health assessment and education.

Asthma education is coordinated with existing community education programs to promote the utilization of currently available services. Follow-up calls are conducted for Members who continue to accrue potentially preventable utilization of the emergency department and/or hospitalization to assess for possible barriers to care and compliance.

Members who require intensive assessment and education are referred to asthma disease management education. Education is provided on an individualized basis over several visits to promote Member control and knowledge about their disease. A referral to a partnering community agency may be submitted for an assessment of the home environment by a Certified Asthma Specialist, and recommendations are given to decrease the risk of an acute asthma episode.

Our goal is to provide programs that encourage our Members to actively participate in their asthma management in collaboration with their physician. As part of the initiative, the primary care provider may receive a copy of the Members' health assessment tool with a summary of the assigned risk status and educational outreach Community First has initiated for each Member. Home assessment and education information is also sent to the primary care provider for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data receive utilization and pharmacy profiles for inclusion in the Member's medical record.

HEALTHY MIND: BEHAVIORAL HEALTH PROGRAM

Community First's staff aids Members in need of behavioral health services. Professional counselors are contracted and ready to help with areas such as aggressive behavior, anxiety, grief, depression, stress, eating disorders, emotional and physical abuse, and more.

A study released in February 2019 by the Meadows Mental Health Institute titled Bexar County Children and Youth Rapid Behavioral Health Assessment reveals that 130,000 Bexar County children between the ages of six and 17, out of 340,000 (38 percent) suffer some form of behavioral illness to include mental health disorders, substance abuse, or a combination. The study reveals that in San Antonio, as well as across Texas, diagnosis and treatment of behavioral health-related issues remain primarily reactionary versus preventative. This is further exacerbated by the fact that Texas ranks last in the United States for youth access to mental health care.

In response to such staggering statistics, Community First developed **Healthy Mind: Behavioral Health Program** to better meet the needs of Members and Providers, increase awareness of mental and behavioral health services, and impact the overall health of our Members.

Program goals include:
Members: Improve Members' adherence to their physicians' treatment plans by addressing underlying behavioral concerns and facilitating life behavior changes to manage medical health better.

- Empowering Members to manage their behavioral symptoms.
- Guiding Members in identifying sustainable solutions to their symptoms.
- Educating Members about their illness(es) and effective treatments.
- Connecting Members with other available Case Management benefit providers to foster continued improvement.
- Advocating for each Member's needs and goals by understanding and respecting the Member's value system while searching for necessary funding, appropriate treatment, and treatment alternatives.
- Integrating medical and behavioral components of treatment to produce long-lasting results.

Providers: Facilitate continuity and coordination of care among physicians and other health care Providers by collecting data on:

- Exchange of information.
- Appropriate diagnoses, treatment, and referrals of BH disorders commonly seen in primary care.
- Appropriate use of psychotropic medications.
- Management of treatment access and follow-up for Members with coexisting medical and behavioral disorders.
- Identifying the special needs of Members with severe and persistent mental illness.

HEALTHY HEART: BLOOD PRESSURE MANAGEMENT PROGRAM

Community First's **Healthy Heart: Blood Pressure Management Program** is designed to promote effective management of hypertension through the provision of disease management education and Case Management assistance. Healthy Heart enables

Members diagnosed with hypertension to maintain their health and optimally manage their chronic disease condition by preventing health problems, protecting from health threats, and promoting health of self and others.

Hypertension is a common chronic health condition that can cause catastrophic harm to a patient's body, leading to potential disability, diminished quality of life, stroke, heart attack, heart failure, and kidney disease. There are many risk factors associated with high blood pressure, including age, family history, race, ethnicity, sex, and an unhealthy lifestyle.

The program incorporates a comprehensive multi-disciplinary, continuum-based process to health care delivery. Community First proactively identifies populations with, or at risk for, chronic illnesses and provides person-based education and interventions to advance Member well-being and quality of life. It allows for a patient-centered approach that holistically addresses the disease management needs of Community First's Members and:

- Supports the physician/patient relationship and plan of care.
- Emphasizes prevention of exacerbations and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies, such as disease self-management.
- Meets the needs of individuals with specific chronic conditions.
- Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

Members enrolled in **Healthy Heart** receive ongoing, age-appropriate education on high blood pressure, appropriate use of medication, exercise, and kidney disease. Members are also provided a list of community resources offering blood pressure, nutrition, and fitness programs.

HEALTHY LIVING: HEALTHY LIFESTYLE MANAGEMENT PROGRAM

Healthy Living: Healthy Lifestyle Management Program was developed to address healthy eating, active living, and tobacco avoidance, and aligns with the U.S. Preventive Services Task Force (USPSTF) recommendations. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.

The 2019 Bexar County Community Health Assessment Report reflected the following:

- **Healthy eating:** Recent surveys showed that just 19.1 percent of Bexar County adults consumed fruits and vegetables five or more times per day.
- **Physical activity:** The percent of Bexar County adults reporting participating in 150 minutes or more of aerobic physical activity per week has remained flat in recent years, estimated at 44.8 percent.
- **Obesity:** Approximately 68.8 percent of adults report a height and weight that puts their Body Max Index (BMI) in the overweight or obese range.

Members enrolled in **Healthy Living** receive ongoing, age-appropriate information on stress management, quitting smoking, exercise, and a heart-healthy lifestyle. Members are also provided a list of community resources offering nutrition information, smoking cessation, and exercise classes.

Higher-risk Members are also referred to one-on-one intensive education which provides education on the importance of regular checkups, exercising regularly, following a meal plan, taking necessary medication, and maintaining a recommended weight in conjunction with other current acute or chronic conditions.

IX. BILLING AND CLAIMS ADMINISTRATION

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

SUBMISSION OF CLAIMS

The address for submitting Community First claims is:

Community First Health Plans, Inc.
Attn: Community First Insurance Plans Claims Appeals
P.O. Box 240969
Apple Valley, MN 55124

Direct any questions regarding claims to Community First Provider Relations at **210-358-6030**.

Community First claims are processed within thirty (30) days of receipt of the claim.

To be considered a clean claim, the red line **CMS 1500 Claim Form and Instruction Table (Exhibit 11)** or the **UB 04 Claim Form and Instruction Table (Exhibit 12),** as applicable, must include the minimum elements for such claim forms required by Texas Department of Insurance regulations in 28 Texas Administrative Code (TAC) §21.2803, as amended from time to time, as required by any statute or regulation that may supersede 28 TAC §21.2803. If Community First requires additional elements or attachments, it shall give Providers at least ninety (90) days notice of the additional requirements.

Please Note: When billing outpatient surgery revenue codes on a **UB 04 Claim Form and Instruction Table (Exhibit 12)** the corresponding CPT-4 procedure code must also be billed. The CPT-4 procedure code must be specific. Unlisted codes are not acceptable.

Only claims including all required information are considered clean claims.

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

FILING DEADLINES

1. Community First must receive clean claims within ninety-five (95) days of the date of service.
2. Claims received after the filing deadline will be denied payment.

PROOF OF TIMELY FILING

Community First accepts the following as proof of timely filing:

- Certified mail receipt
- Rejection notices
- Electronic confirmation from Availity®
- Log listing claims with Member name and date of service if signed by both the Provider and a Community First representative

APPEAL DEADLINES

Providers have the right to appeal the denial of a claim by Community First Insurance Plans. To file an appeal, Providers should submit the Claims Appeal Form and a copy of the EOP, along with any information related to the appeal.

For more efficient processing, please fill out the Claims Appeal Form electronically using our secure Provider Portal. For assistance navigating the portal or to create an account, please email ProviderRelations@cfhp.com or call **210-358-6294** to contact our Provider Relations Department.

Forms with inaccurate information will be rejected and will receive a rejection notification from our Claims Department.

If you prefer to file an appeal by mail, please download, complete, and print our paper Claims Appeal Form and mail it to the address below:

Community First Health Plans
Attn: Appeals Department
P.O. Box 240969
Apple Valley, MN 55124

Please note: Appeals submitted without the Claims Appeal Form will be rejected.

ELECTRONIC DATA INTERFACE (EDI)

To submit electronic claims, Providers may use one of the following methods:

- **Provider Portal:** Providers may submit batch claims or individual claims electronically using Community First's secure Provider Portal.
- **Availity® – Clearinghouse:** Community First accepts electronically submitted claims through Availity®. Claims filed electronically must be filed using the 837P or 837I format. Billing instructions can be found at the Availity® website. Electronically submitted claims must be transmitted through Availity® using Community First's Payor Identification as indicated below:
  - Community First Payor ID: COMMF
  - Community First Receiver Type: F
- **Electronic Claims**
  - Provider Portal Electronic Billing:
    - Claim MD
    - Availity®

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

NEGATIVE BALANCES

Community First has the right to recover overpayments made to Providers. If a negative balance exists on an Explanation of Payment (EOP), maintain a copy of the EOP for future reference.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is when a Member is covered under one or more other group or individual plans, such as a plan sponsored by their spouse's employer. An essential part of coordinating benefits is determining the order in which the plans provide benefits.

One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plan(s) then become secondary.

EXPLANATION OF PAYMENT – PAYSPAN

1. You will receive an **Explanation of Payment (EOP)** (**Exhibit 13**) detailing:
   - Date of service
   - Place of service (location code)
   - Diagnosis code
   - Procedure code
   - Modifier
   - Type of service
   - Days/count
   - Amount billed
   - Allowed (contracted) amount
   - Deductible/copay amount
   - Other insurance payment (TPP)
   - Amount denied
   - Total benefit paid to the Provider
   - Reason(s) for denial or nonpayment (explain codes)
2. It is imperative that you review your EOP to determine the reason(s) for the denial. If you do not review your EOP, you will jeopardize your opportunity for appeal.
3. If negative services balance exists on the EOP, maintain a copy for future reference.
4. The address page of the EOP will also be used for messages to Providers that are of significance for claims submission and payment.

EOP, DUPLICATE CHECKS, AND CANCELED CHECK REQUESTS

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

Check printing errors that result in duplicated checks should be reported to Community First as soon as identified. The Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed.

Any bank fees that the Provider accrues after the Provider deposits or cashes a duplicate check will not be reimbursed by Community First.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of $15 per EOP and $20 per check. The request for a copy of the EOP and/or check must be submitted in writing along with the appropriate fee. The request must include the date of the EOP, the name of Provider, and date of the check. Send the request to:

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

CLAIMS EDITING SOFTWARE

In addition to the claims adjudication platform, the Claims Editing Software (CES) automatically reviews and edits both physician and facility claims.

The CES knowledge base helps maximize claims accuracy, administration, and clinical information workflows by delivering Medicaid-specific editing. Claims editing software maintains Medicaid claim editing rules issued by the Centers for Medicare & Medicaid Services (CMS), as well as those issued by individual states or territories.

Comprehensive commercial, Medicaid, and Medicare editing is done for professional/facility claims. The system automatically detects coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, duplicate claims, diagnosis to procedure appropriateness, maximum frequency per day editing, new patient visit auditing, bilateral procedure reductions, and anesthesia processing. Quarterly updates keep the editing rules current with regulatory and coding guidelines.

PROVIDER UNDER INVESTIGATION

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

CLAIMS PAYMENT

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

FRAUD, WASTE, AND ABUSE

The Provider understands and agrees to the following:

- Community First and/or the Office of Inspector General (OIG) must be allowed to conduct private interviews of Providers and their employees, agents, contractors, and patients;
- Requests for information from such entities must be complied with in the form and language requested;
- Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation,

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

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

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

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

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

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

Community First considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive, and/or attempting to obtain unjustly benefit payments is only considered if there is documented previous education in writing or in-person by Community First regarding the same or similar adverse audit findings or there are obvious program violations.

Procedures for Detecting Possible Acts of Waste, Abuse, or Fraud by Providers

Audits

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

1. **Data matching** – procedures, treatments, supplies, tests, and other services, as well as diagnosis billed, are compared for reasonableness using available sources, including the American Medical Association (AMA) and Centers for Medicare and Medicaid Services. Comparisons include age, gender, and specialty when applicable.
2. **Analysis** – inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of Providers' activities lists outliers based on particular specialties and across all specialties and includes procedures, modifiers, and diagnosis. Pharmacy data may be reviewed if provided in a usable format by Community First's pharmacy benefits manager.
3. **Trending and Statistical Activities** – The SIU uses Electronic Data Interchange (EDI) Watch software to build Provider profiles that show trends and patterns of submissions based on key claim elements and include Providers' patient activities. Statistical analysis shows Provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

Monitoring

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

Anti-Fraud Hotline

Community First maintains an anti-fraud hotline at **210-358-6332** to allow reporting of potential or suspected violations of waste, abuse, and fraud by Members, Providers, and employees. A recording device is utilized to capture calls. Messages left on the recording device are answered by SIU personnel within two (2) business days.

The hotline number is printed on appropriate Member and Provider communications and published on the Community First website. The hotline number is also included in this Provider Manual and Member Handbooks.

The SIU maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

Random Payment Review

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

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

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

Procedures for Detecting Possible Acts of Waste, Abuse, or Fraud by Members:
The SIU utilizes software flags for detecting possible acts of waste, abuse, or fraud by Community First Members. Flags include:

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

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

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

Procedures for Determining General Overpayments:

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

Findings Considered General Overpayments:

- Billing errors
- Insufficient documentation to support billed charges
- Inappropriate use of modifiers
- Incorrect billing provider
- Duplicate claims
- Billing for different authorized services
- Data matching of diagnosis and procedure codes
- Unbundling of services, procedures, and/or supplies
- Claim processing errors

Time Limitation for Review of General Overpayments:

- Recovery of discovered general overpayments will be initiated for a minimum of two (2) years in which the explanation of original payment was made.
- Only the year of the payment and the year it was found to be a general overpayment enter into the determination of the calendar year period. The day and the month are irrelevant.
- Clear evidence of intentional fraud, waste, abuse, or program violation is excluded from general overpayment reviews.
- Preliminary investigations and full investigations are excluded from determining general overpayment findings.

Consideration of General Overpayments

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

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

SIU Process for Recovery of Overpayments

The SIU has established the following process regarding recovery of overpayments discovered through investigations including preliminary investigations. Overpayments will be processed in the following manner:

- Upon completion of the investigation and final disposition of any administrative, civil, or criminal action taken by the state or federal government, Community First SIU will determine and direct the collection of any overpayment.
- Overpayments collected as a result of an investigation will be distributed to Community First unless an alternative distribution is indicated.
- If Community First is not entitled to all or any portion of the distribution of funds collected as a result of an overpayment, the appropriate regulatory agency will provide Community First with a written explanation indicating the rationale for the alternative distribution of funds.
- Referrals are made to the OIG at the conclusion of an audit if there are suspicious indicators of fraud, failure to supply information requested (medical records, etc.), or suspicious activity. For overpayments under $100,000, Community First proceeds with recovery of the overpayment. For overpayments over $100,000, Community First must wait for OIG to determine if they will open a case or return it to the

Managed Care Organization (MCO). If they do not accept the case, Community First will recover the overpayment.
- Community First provides education to Providers and documents educational efforts regarding audit findings and coding compliance.
- Community First SIU recovers overpayments discovered by auditing and monitoring efforts via claims adjustments and accounts for these recoveries in cost reports. The Community First SIU has established the following process regarding recovery of general overpayments discovered through reviews and audits excluding investigations.

Commercial HMO Program General Overpayments
Notification of overpayments will occur after the completion of an audit, or review and will:

- Be in writing and include the specific claims and amounts for which a refund is due.
- Provide the basis and specific reasons for the request for refund.
- Include notice of the physician's or Provider's right to appeal.
- Describe the method and due date by which the refund will occur.
- Describe actions that will occur if overpayment is not refunded.

Commercial/HMO Program General Overpayment Appeal Process

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

Non-Voluntary Repayment of Overpayments
Non-voluntary repayment of overpayments will result in any or all the following actions:

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

Time Limitation for Recovery of Overpayments

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

Provider and Recipient Fraud, Waste, and Abuse Education
Members and Providers are offered fraud, waste, and abuse education through a variety of avenues including the Community First website, Member and Provider newsletters, Provider Manuals, and Member Handbooks. The information contained in these materials includes the definitions and examples of fraud, waste, and abuse and how to report fraud, waste, and abuse.

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

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

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

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

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

- The Provider must have specific recollection of the services provided which is documented.
- A Provider may add a missing signature without a time restriction if the Provider created the original documentation themselves.
- The above does not restrict or limit the Provider's ability to document or amend medical records at any time to more accurately describe the clinical care provided to the patient.
- For medical record review/audit and reimbursement purposes, documentation is not considered appropriate and/or timely documented if originally completed after thirty (30) days of the date of service.

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

Addendum: Provides additional information that was not available at the time of the original entry. The addendum should be timely, reflect the current date, include the Provider's signature, and include the rationale for the addition or clarification of being added to the medical record.

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

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

- All entries are clearly documented and legible to individuals other than the author, include date (month/day/year), and be signed by the performing Provider.
- Notations of the beginning and ending session times for counseling and/or each test administered.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Name of test(s) (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI])
  - Background and history of client and reason for testing
  - Behavioral observations during the session
  - Narrative description of the counseling session or test findings
  - Diagnosis (symptoms, impressions)
  - Treatment plan and recommendations
  - Explanation to substantiate the necessity of retesting, if applicable

Reporting Provider/Recipient Fraud, Waste, and Abuse
Community First has established several mechanisms that can be utilized for the reporting of suspected acts of waste, abuse, and fraud. The **Suspicious Activity Report Form (Member) (Exhibit 14)** and **Suspicious Activity Report (Provider) (Exhibit 15)** are available and may be requested by your Provider Relations Representative. Suspicious activity may be reported as follows:

- In writing:
  Community First Health Plans
  Attn: Community First Insurance Plans Special Investigations Unit
  12238 Silicon Drive, Ste. 100
  San Antonio, TX 78249

- By phone:
  Fraud, Waste, and Abuse Hotline Message Center: **210-358-6332** or Community First Insurance Plans Member Services: **1-800-434-2347**

XI. COMPLAINTS & APPEALS

ADVERSE DETERMINATION

If you wish to appeal an adverse decision made by Community First regarding the health care service or services proposed for a Member, you or the Member may appeal the Adverse Determination orally or in writing.

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

1. Within five (5) working days from receipt of the appeal request, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the appeal. This letter will include a reasonable list of documents to be submitted to Community First for consideration during the appeal.
2. When Community First receives an oral appeal of adverse determination, Community First will send the appealing party a one-page appeal form.
3. Emergency care denials, denials for care of life-threatening conditions, and denials of continued stays for hospitalized patients can be requested as an expedited appeal process. This process will include a review by a health care provider who has not previously reviewed the case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.
4. The time frame in which an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one (1) working day following the date the appeal, including all necessary information to complete the appeal, is submitted to Community First.
5. After review of the appeal of the Adverse Determination, Community First will provide written notification to the Member and the Member's physician or health care provider explaining the resolution decision of the appeal. Community First will provide written notification to the appealing party as soon as possible, but no later than thirty (30) days after receipt of the written appeal or completed appeal form. The notification will include:
   a. A clear and concise statement of the specific medical or contractual reason for the resolution.
   b. The clinical criteria for such decision.
   c. The source criteria used in the decision.
   d. The specialty of any physician or other provider consulted in the appeal process.
   e. If the appeal is denied, the written notification will include notice of the appealing party's right to seek a review through an Independent Review Organization (IRO) (See Chapter XI. Appeals, Member Complaints and Appeals.)
   f. Denials for care of life-threatening conditions can be appealed directly to the Independent Review Organization as outlined in the denial letter.

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

CLAIM DENIALS

Providers have the right to appeal a claim denied by Community First. Providers have ninety (90) days from the date of Community First's Explanation of Non-Payment to

appeal the denial. Community First's Claims Department will not accept any appeal(s) received after the appeals deadline.

Providers must mail the appeal to Community First Claims Resolution Department at the following address:

Community First Health Plans, Inc.
Attn: Community First Insurance Plans Claims Resolution Department
P.O. Box 240969
Apple Valley, MN 55124

The **Claims Department Appeal Submission Form (**Exhibit 16**)** should be used when submitting appeal.

MEMBER COMPLAINTS AND APPEALS

If a Member has a problem or concern regarding the delivery of their health care services, they can call Member Services at **210-358-6040** or **1-888-512-2347** (TTY **210-358-6080**). A Member Services Representative will assist the Member with their issues and concerns.

APPEALS OF "FOR CAUSE" TERMINATION OF HIE AGREEMENT

According to your agreement with Community First, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it can terminate immediately and without notice under certain circumstances.

If in receipt of a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure.

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

Upon termination of your agreement, you may file an appeal with Community First's Medical Director by registered or certified mail within thirty (30) days of receiving the notice of termination. Please include any explanation or other information to be considered with your request for an appeal.

Community First's Medical Director will appoint a committee to review your request and any additional information or explanation provided within thirty (30) days of receipt. The committee will make a recommendation to Community First to either reaffirm your agreement, reaffirm your agreement with sanctions, or uphold your termination.

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

PROVIDER COMPLAINTS AND APPEALS

Community First has a process to address Provider complaints in a timely manner that is consistent for all network Providers. Community First and the Provider have an obligation under their mutual contract provisions to make a good-faith effort to resolve any disputes arising under the agreement.

In the event a dispute cannot be resolved through informal discussions, the Provider must submit a complaint to Community First, which specifically sets forth the basis of the complaint along with a proposed resolution. Providers should submit complaints, verbally or in writing, to Community First's Network Management Department.

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

Provider Complaints
Upon receipt of a written Provider complaint, Community First's Network Management Department will send a letter acknowledging receipt of the complaint within three (3) working days from the date of receipt. If the Provider complaint is received orally, Network Management will send a **Provider Complaint Form (Exhibit 17)** with a transmittal letter. The Provider must complete the form and return to Community First's Network Management Department for prompt resolution of the complaint.

Once the **Provider Complaint Form (Exhibit 17)** is received by Network Management, a letter will be sent acknowledging receipt of the complaint within three (3) working days from the date of the receipt.

Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First's resolution of the complaint to the Provider within thirty (30) calendar days from the receipt of the written complaint or completed **Provider Complaint Form (Exhibit 17).**

Provider Appeals
If the Provider and Community First are unable to resolve the complaint, the Provider may submit an appeal, orally or in writing, to Community First. Upon receipt of a written appeal, Community First will send a letter acknowledging the request for an appeal within three (3) working days from the date of receipt. If the appeal is received orally, Network Management will send a **Claims Department Appeal Submission Form (Exhibit 16)** for the Provider to complete and return to Community First.

Community First will send written notification within thirty (30) calendar days from the receipt of the appeal to the Provider of the acceptance, rejection, or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First's final determination. The notification will advise the Provider of their right to submit the appeal to binding arbitration. Any binding arbitration will be conducted

in accordance with the rules and regulations of the American Arbitration Association unless the Provider and Community First mutually agree to an alternative binding arbitration procedure.

UNIVERSITY COMMUNITY CARE PLAN

PROVIDER MANUAL

UNIVERSITY COMMUNITY CARE PLAN
COMMUNITY FIRST

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