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# I. Plan and Member Information

## A. Overview and Eligibility

Cox HealthPlans (CHP) offers several types of health benefit plans in the Springfield and Southwest Missouri regions:

- Cox Health Systems Group HMO
- Cox Health Systems Group HMO/Point of Service (POS) Rider
- Cox Health Systems Insurance Company Group PPO Plan
- Cox Health Systems Insurance Company Individual PPO Plan
- L.E. Cox Medical Centers Employees Self-Funded Plan
- Cox Health Systems Insurance Company Group Metal Plan (MG)
- Cox Health Systems Insurance Company Individual Metal Plan (ML )

Providers may obtain the most up-to-date Member eligibility information by first visiting www.coxhealthplans.com, or by then contacting the CHP Member Services Department (contact information is listed on Appendix E. herein).

**HMO Primary Care Provider (PCP)**

Under the HMO Plan, Members may access any participating PCP or Specialty Provider in the network at their own discretion without plan approval. Members are responsible for out-of-pocket co-payments at the time of service.

Cox HealthPlans has no referral requirement for in-network Specialist care, some services do require prior authorization from CHMO. Services requiring prior authorization are listed in Section III, Medical Management Policies and Procedures, Item A., Prior Authorization, as well as in the Member's Evidence of Coverage/Benefits booklet.

**HMO/Point of Service (POS) Rider**

If the member is enrolled in an HMO with a POS rider added, the HMO member may elect to receive covered services outside of the CHMO network. The Member is then responsible for a deductible, a percentage of the allowable usual and customary charge, and any amount over usual and customary. In addition, when a non-network Provider renders certain types of non-emergency care, it is the Member's responsibility to obtain prior authorization.

When prior authorization is not obtained, the Member will bear greater financial responsibility for the service. Services requiring prior authorization are listed in Section III, Medical Management Policies and Procedures, Item A., Prior authorization, herein.

**PPO Members**

Group and Individual PPO members are not required to select a PCP. For a list of services that require prior authorization, please see Section III, Medical Management, Item A., Prior Authorization. When a PPO member utilizes a non-Network Provider, it is the Member's responsibility to obtain prior authorization for services that require authorization. For questions about Plan exclusions, please contact the Member Services Department. PPO Members are responsible for varying deductibles, co-pays and co-insurance amounts per their plan. For Member-specific information please use the provider web portal at www.coxhealthplans.com.

**B. Member Identification Card**

CHP provides each Member, regardless of plan type, with his/her own unique member identification card.

All CHP Members have the responsibility to present their valid member identification card at the time they seek medical services. Providers may obtain the most up-to-date Member eligibility information by first visiting www.coxhealthplans.com, or by then contacting CHP Member Services at (417) 269-2900 or (800) 205-7665. Samples are included as Appendix A.

# II. Provider Information and Guidelines

## A. Office Procedures

Upon acceptance into the network, Cox HealthPlans notifies the provider of their Provider Identification number. A Provider Manual is available to all participating Providers upon acceptance into the network by accessing CHP's website or by calling the Member Services Department and requesting a hard copy.

When seeking specific Member or claim information, please have at least the following information available for use on the CHP Provider Web portal:

1. Member's name;
2. CHP's Member identification number;
3. Date of service; and
4. Other information needed to identify the claim within the system.

## B. Medical Records

Cox HealthPlans (CHP) believes that appropriate documentation is an essential component of quality care. Medical record guidelines and review procedures have been developed to comply with Center for Medicaid & Medicare Services (CMS) and other nationally recognized standards. These guidelines support consistent and complete documentation of each Member's medical history and treatment.

Participating Providers may be asked for copies of Members' medical records for administrative, financial, legal, and quality improvement activities including HEDIS. These record requests fall under the treatment, payment and health care operations under HIPAA, and do not require any special release from the member prior to submission. Examples include, but are not limited to:

- Quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination;
- Evaluating provider and health plan performance, accreditation, certification, licensing, or credentialing activities;
- Review of medical records to determine benefits , claims payment, and/or Risk Adjustment (RA)

Participating Providers are required to participate in CHP's Quality Assurance and Utilization Management activities. In many instances, this is accomplished by making medical records available to the appropriate network or health plan representative

Standard Request for Medical Records for Claim or Benefit determination

- Initial request sent
- Second request in 30 days from initial request

Records not submitted within the requested time frame will result in the Claim and/or Benefit request being pended.

Standard Request for Medical records for Prior Authorization Benefit Determination

- Initial request sent to provider following their request for Prior Authorization

- Second notice letters will be faxed in 6 workdays from the initial request
- Third notice sent at 10 workdays from initial request
- Final Closed notice letters will be generated 14 workdays from initial request
- REQUEST CLOSED

CHP will be able to resume processing upon receipt of the requested information if received within the above timeline. All Closed requests will need to be reinitiated.
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**CHP medical record (paper or electronic) guidelines include:**

- All physicians' medical records must meet specifications per Missouri regulations.
- Each Provider office shall have policies and procedures in place regarding confidentiality and retention that comply with state and federal requirements. At a minimum, medical records must be retained for the longer of seven years and/or seven years after the age of patient majority or as required by the State.
- Medical records are to be systematically organized to allow for efficient review. It is CHP's recommendation that all documents be firmly attached to the file. Individual medical records are recommended as opposed to family medical records.
- Medical records must be legible for individuals other than the writer.
- The patient's name and other appropriate identifying information are to be indicated on each page of the file. Personal/biographical information contained within the file should include marital status, family information, address and phone numbers, employer name and type of work.
- Past medical history and treatments, including a problem list outlining significant illnesses and medical conditions, food and/or drug allergies and adverse reactions (including "no known allergy" information), prior accidents, operations or illnesses, documentation of smoking habits and/or history of substance abuse and other health risk factors should be clearly identified within the medical record.
- All entries are to be dated and signed.
- All who enter information are identified.
- The reason for the encounter, including relevant history and physical exam findings, subjective and objective information, and prior diagnostic test results are to be documented. Information on unresolved problems from past medical visits should be included.
- Working diagnoses are to be documented and treatment plans are to be consistent with diagnoses.
- Notations regarding follow-up calls or visits for unresolved problems are to be identified and specific time of return is to be noted in weeks, months or as needed. Actual follow-up is to be noted.
- Providers should note when the patient was offered and when the patient received preventive screening and services according to nationally recognized practice guidelines. The medical records should indicate when test results were reviewed by the Provider and shared with the patient.

- Reasons for consultation, lab and other diagnostic testing and follow-up treatment should be clearly outlined in the patient's medical file and should be medically appropriate for the working diagnosis. When consultants are requested, the requesting Provider will make applicable medical record information available to the consulting Provider.
- Consultant notes, lab, imaging and other diagnostic test reports are to be initialed and dated by the reviewing Provider. Information should be contained within the medical record indicating when the patient or appropriate responsible party was notified of the results. If the results are abnormal, there must be explicit notes regarding follow-up plans.
- For children, a complete immunization record must be available within the record.
- Medical records should support the ICD-9, CPT-4, and HCPCS coding reported to health insurance companies.

**C. Access Standards**

**HMO and PPO**

- Providers serving HMO Members must comply with Section 354.606 RSMo. and shall: not discriminate in the treatment of Members or in the quality of services delivered to Members on the basis of (a) race, sex, religion, national origin, health status, or source of payment; (b) observe, protect, and promote the rights of Members as patients; (c) provide care and services which are of a quality consistent with generally accepted standards and practices in the medical community; and (d) not seek to transfer Members from a practice based solely on the Member's health status.
- Providers must demonstrate twenty-four (24) hour-a-day, seven (7) day-a-week call coverage by participating network Providers.
- Providers must comply with 20 CSR400-7.095.
- All patients should be seen within one (1) hour of the scheduled appointment time.
- Routine care patients, without symptoms, should be seen within (30) thirty-days from the time the enrollee contacts the Provider.
- Routine care patients, with symptoms, should be seen within one (1) week or five (5) business days from the time the enrollee contacts the Provider.
- Urgent care for serious, but non life-threatening illnesses/injuries to patients should be available within twenty-four (24) hours from the time the enrollee contacts the Provider.
- Pursuant to Section 354.603, RSMo., access to emergency care for serious and/or life-threatening illnesses or injuries shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care.
- Obstetrical care patients should be seen within one (1) week for enrollees in the first or second trimester of pregnancy and within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days a week for enrollees who require emergency obstetrical care.

- Mental healthcare patients must have telephone access to a licensed therapist twenty-four (24) hours per day, seven (7) days per week.

**D. Provider Appeal Process**

Provider appeals regarding payment issues must be received within one (1) year from the payment or denial date. A Provider may fax or mail a written appeal regarding an adverse determination made by CHP to the Provider Appeals Department at the address/fax numbers listed on Appendix E herein. Appeals should include appropriate medical documentation (i.e., medical records, operative notes, etc.) as necessary.

CHP's Provider Appeals Department will review all grievances. CHP will furnish the Provider with a written response after review of the appeal documentation.

If the Provider filing the appeal is not satisfied with the determination of CHP, the Provider shall have the right to request a second reconsideration of the original decision. **The written request must be accompanied by new additional clarifying supporting documentation**. These may be mailed or faxed to the address/number listed on Appendix E. The Provider will receive an acknowledgement of receipt within twenty (20) working days and will be notified in writing of the Plan's decision regarding the second request. This decision shall be final.

**E. Termination**

Providers may voluntarily terminate their participation in CHP by providing at least sixty (60) days written notice to the network. It then becomes the responsibility of the network to notify CHP. Adequate notice also allows for claims incurred, but not yet received by the plan, to be processed correctly and permits CHP to transition a Member's care to another Provider. The resigning Provider is required to care for his/her CHP members, regardless of whether the Member is well or ill, until the sixty (60) day notification period has elapsed.

The Plan may terminate a provider with sixty (60) days notice, and shall provide a written explanation of the reasons for the proposed termination and an opportunity for a review or hearing (not applicable to cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency).

The notice of the proposed termination provided by the Plan to the provider shall include the reasons for the proposed action, notice of the right to request a hearing or review (at the provider's discretion) before a panel appointed by the Plan, a time limit of not less than thirty (30) days within which the provider may request a hearing, and a time limit for a hearing date to be held within thirty (30) days after receipt of a request for a hearing. The panel shall be comprised of at least three (3) persons appointed by the Plan. At least one person shall be a clinical peer in the same discipline or the same or similar specialty as the Provider under review. If greater than three (3) persons, the panel must be composed of at least one third clinical peers.

The hearing panel shall render a decision in writing within fifteen (15) days after the hearing and shall include either reinstatement, provisional reinstatement subject to conditions set forth by the Plan, or termination of the provider. The decision will be effective not less than thirty (30) days after receipt by the provider of the hearing panel's decision, and shall not be effective any earlier than sixty (60) days from the receipt of the notice of termination. (RSMo 354.609.)

In certain instances, CHP may request that a terminating Provider continue to care for a particular patient beyond the sixty (60) day notification period if the transition of care is unfeasible or may compromise the health of the patient. This clause will be invoked only until the patient's care can be safely transferred to a Participating Provider for a maximum ninety (90) day period.

CHP and our network partners may not terminate a Provider during an active investigation of a complaint or appeal initiated by a Member or by the Provider on behalf of a Member. This applies to a complaint and/or appeal filed either directly to CHP or to the Department of Insurance.

# III. Medical Management Policies and Procedures

## A. Prior Authorization Process

Certain procedures or services for the different benefit plans require Plan approval or Prior Authorization. The prior authorization process assures that the Member is eligible, that the service is a covered benefit and it's medically appropriate. If, at the time of prior authorization, eligibility and coverage criteria are met, an authorization number is assigned by CHP. Benefit information may be obtained by contacting CHP Member Services. Please note this list is subject to change. Providers will be notified of any future changes. Please see the following table for Cox HealthPlans prior authorization requirements:

**Authorization Requirements for Cox HealthPlans**

| SERVICE | HMO | POS | CHSIC PPO / SELF FUNDED PLANS | CHSIC INDIVIDUAL PLANS | Metal Plans |
|---|---|---|---|---|---|
| Chiropractic Care | No | Non-covered | No | No | No |
| Dialysis | No | Non-covered | No | No | No |
| DME - Outpatient only, except for but not limited to the following: | No | No | No | No | No |
| Insulin Pumps | Yes | Yes | Yes | Yes | Yes |
| Mobility Assisted Equipment (MAE) | Yes | Yes | Yes | Yes | Yes |
| Stimulators (Bone, Neuromuscular, Vagus Nerve) | Yes | Yes | Yes | Yes | Yes |
| Cardiac Vests | Yes | Yes | Yes | Yes | Yes |
| Home PT/INR Monitoring | Yes | Yes | Yes | Yes | Yes |
| Negative Pressure Wound Therapy (NPWT) | Yes | Yes | Yes | Yes | Yes |
| Education, Metabolic (Weight Loss not covered) | No | No | No | No | No |
| Foot Orthotics | No*** | No*** | No*** | Non-covered | Yes |
| Home Health /Hospice | Yes | Non-covered | Yes | Yes | Yes |
| Inpatient Admission | Yes* | Yes | Yes | Yes | Yes |
| Mental Illness (All levels of inpatient care) | Yes | Yes | Yes | Yes | Yes |
| Mental Illness Intensive Outpatient (IOP) or partial hospitalization | Yes | Yes | Yes | Yes | Yes |
| Mental Illness Outpatient (all other) | No | No | No | No | No |
| Outpatient Plastic or Oral Procedures | Yes** | Yes** | Yes** | Yes** | Yes |
| Outpatient Speech Therapy | Yes | Yes | Yes | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Outpatient Surgery | No | Yes | No | No | No |
| Outpatient Testing – Except for, but not limited to: | No | No | No | No | No |
| PET Scan | Yes | Yes | Yes | Yes | Yes |
| Prosthetics | Yes | Yes | Yes | Yes | Yes |
| Referral to Extended Network (i.e. Barnes Jewish, Univ. of MO) | Yes | Yes | No | No | No |
| Scheduled Ambulance | Yes | Yes | Yes | Yes | Yes |
| Skilled Nursing Facility / Rehab | Yes | Yes | Yes | Yes | Yes |
| Substance Use Disorder (All levels of care) | Yes | Yes | Yes | Yes | Yes |
| Transplants | Yes | Non-covered | Yes | Yes | Yes |
| Specific Rxs: See Section VI, A, D herein | Yes | Yes | Yes | Yes | Yes |

** Inpatient – HMO no authorization required for obstetric deliveries.*
*** Outpatient Plastic – Any procedure that could be considered potentially cosmetic (i.e.: septoplasty, blepharoplasty, questionable skin lesion removal)*
**** Foot Orthotics – Coverage for diabetics only.*
***Any Non-Participating or Out-of-Network service requires prior authorization for HMO or POS.***

**Note:** When a Member is enrolled in the PPO or POS rider plans, it is the Member's responsibility to insure that prior authorizations are obtained and are current and accurate. If notification is not provided, the non-compliance reductions will be applicable as indicated within the member's plan document. ***HMO <u>POS</u> non-covered means services must be provided by an in-network provider to be a covered benefit.***

Please contact Member Services for additional information or with any questions.

## B. Information Required For Prior Authorization

Providers must fax or mail this information to CHP when prior authorization is necessary. A sample prior authorization formis attached in Appendix B. This form is to be used as a tool to ensure all pertinent information is available. CHP Medical Management Department will only review and process requests that have been made using this form. There may be instances where a verbal authorization is requested. Verbal requests will be considered on a case by case instance. Verbal Prior authorizations are subject to the limitations set forth in the member's plan document, and are not a guarantee of payment.

Reconsideration requests for adverse determinations (Denials) can also be made. Requests must be received within 7 days of the original denial date.

## C. Use of Non-Participating Providers

### HMO

For HMO members, all requests for referrals to extended network Providers or to nonparticipating Providers must be pre-approved by the Plan. For HMO members, when a PCP or any participating Provider feels that the appropriate services are not available within the CHMO network, he/she may contact the Medical Management department for assistance with accessing alternative services.

When alternatives are available within the network, CHP will provide the necessary information to the Provider's office. When alternatives are not available, CHP will assist the Provider in arranging either extended network or out-of-network care. When this approval is arranged in advance for non-emergent services, the Member is eligible to receive the highest benefit. Non-emergent services conducted outside of the network, which are not pre-approved through CHP, would not qualify for payment unless the Member has Point of Service (POS) benefits.

### PPO

For PPO members, Plan approval is not required for a member to be referred to, or seek care, in the extended network or outside the network (except as indicated in the prior authorization table). Covered benefits may be obtained and will be covered at the member's out-of-network benefit level.

## D. Medical Management Services

### Case Management/Disease Management

CHP's Case Management staff works closely with facility case managers and ancillary staff to assist Providers with Members who have potentially catastrophic or chronic diagnoses and to coordinate the continuing care requirements of those Members. CHP Case Managers are familiar with other participating networks throughout the CHP service area, the Member's benefits per the EOC, and other available services, which could assist Members in obtaining care at the most appropriate level and setting. When a Case Manager is assigned, they will assist the members and providers in navigating the continuum of care, and help members maximize their benefits as set forth in their plan document.

Providers are encouraged to refer members that they feel would be appropriate for Case Management/Disease Management. Providers should complete the Referral Form found in Appendix C and fax to 417-269-2919.

## E. Requests for Documentation of Medical Conditions for Coverage Determinations

There are times when CHP requires objective evidence of a medical condition in the form of copies of the Member's medical records to determine benefit coverage or adjudicate claims properly. Failure to provide the necessary clinical information will result in these claims(s) being suspended until the information is received. Records must be submitted to CHP within one (1) year of the suspended date or the claim will be denied.
CHP will be able to resume processing these claim(s) upon receipt of the requested information.

Examples of these types of claims include, but are not limited to:

- Breast reduction.
- Treatment of varicose veins.
- Oral or potentially cosmetic procedures.
- Pre-existing conditions.
- Potential fertility work up or treatment
- Inpatient stay
- Any other service requiring Prior Authorization or plan approval

Prompt submission of requested records will assure timely processing of submitted claims.

# IV. Quality Improvement & Utilization Management

CHP, with assistance and support from our Provider partners, accomplishes ongoing quality improvement processes through:

- Systematic monitoring of the appropriateness, accessibility and continuity of care;
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- Measurement of outcomes with feedback to Providers; and
- Retrospective audits of billing practice.

CHP's Quality Improvement activities correlate data extracted from Member and Provider satisfaction surveys, complaints and grievances, service standards, Provider change information, access data, preventive health measurements, HEDIS and outcome data. Upon request, these reports are shared with individual providers.

## A. HMO Credentialing

CHP has established standard credentialing and re-credentialing policies and procedures for Provider participation. These processes conform to NCQA criteria, and state and federal regulations. Practitioners are required to participate in and comply with credentialing and re-credentialing procedures. Failure to do so is grounds for termination from CHP.

CHP may delegate credentialing authority to participating PHOs or other Provider groups after their credentialing programs have been audited for compliance with CHP's credentialing criteria. CHP may conduct audits of the delegated organization's policies and procedures and its performance under these standards through an onsite review or delegated review of Provider files.

The credentialing review process includes, but is not limited to:

1. Primary source verification of current licensure through the appropriate state licensing board, coverage through a malpractice carrier, censure reported via the National Practitioner Databank, or NHPDB, drug certificates, hospital admitting privileges (as applicable), education, specialty training, board certification and employment history;
2. Primary Care Practitioners and other high volume Providers are subject to an office site visit to review the practices, condition and appropriateness of the office setting and a medical records review to assure legibility and provision of adequate documentation of patient care and services.

All information for HMO Providers is evaluated against CHP participation criteria by the entity responsible for credentialing and the Board of Directors of Cox Health Systems HMO, Inc. (CHMO). Participation criteria are evaluated annually. Re-credentialing, which occurs every two (2) to three (3) years, is the verification of a practitioner's credentials and an evaluation of his/her performance through:

1. Member satisfaction surveys;
2. Quality reviews;
3. Member complaints; and

4. Medical record reviews and office evaluations (PCPs and high volume specialists only).

CHP reviews the re-credentialing information and makes recommendations for or against the Provider's continued participation. This information (on HMO providers) is provided to the CHMO board for final approval. CHP's Medical Director may, with the Medical Director of the PHO, review and request the PHO establish a corrective action plan where necessary. This decision is considered final, unless the practitioner appeals the decision.

**B. Quality Improvement Activities**

CHP evaluates the practice patterns of contracted practitioners through a review of clinical events, claims and encounter data, medical record reviews and complaints and grievance activity.

When studies identify opportunities to improve systems or processes, appropriate planning and interventions may take place.

**C. The Health Plan Employer Data and Information Set (HEDIS)**

**HMO Members**

HEDIS is a set of standardized performance measures used to assess the quality of clinical are and services provided by the HMO and other managed care organizations. It involves collecting Protected Health Information (PHI) data, and is the most widely used set of performance measures in the managed care industry. HEDIS measures are developed and maintained by the National Committee for Quality Assurance (NCQA), and The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

HEDIS was originally designed to address employers' needs as purchasers of health care to compare managed health care plans. Now HEDIS information is providing a reliable way for consumers to make comparisons and informed choices as to their health care plan. Additionally, policymakers use HEDIS data in guiding efforts to improve the health care system.

Cox HealthPlans is mandated by the State of Missouri to report on select measures each year.

The final rule removed obstacles to acquiring access to HEDIS data.

- Clarified that the definition of Health Care Operations includes evaluating health plan performance. The definition of health care operations includes: "(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance…" [45 FR 164.501]
- Eliminated the consent requirement when PHI is used or disclosed for Health Care Operations [67 FR 53182]. For example, a health care provider may disclose PHI to a health plan for the plan's Health Plan Employer Data and Information Set (HEDIS) purposes provided the health plan has/had a relationship with the individual who is the subject of the information.

- Section F. Agreement and Authorization of the CHP Enrollment Application authorizes "any provider…in possession of information relating to the history, diagnosis, prognosis, treatment, or care as to any condition may release the same to CHP or its authorized designee, who may release such information in connection with…managing the provision of services, insurance and any other lawful purpose relating to coverage."

The plan holder's signed enrollment form authorizes CHP to receive PHI on the plan holder and all of his/her dependents for the purpose of health care operations and remains valid for the term of coverage.

HEDIS evaluates several areas of a managed care organization's performance, including:

- Effectiveness of care
- Access/availability of care
- Use of services
- Health plan stability
- Member satisfaction

Within these areas, numerous performance measures are selected based on their relevance and value to employers and Members through their potential to improve the health care delivery process. HEDIS measures are collected using administrative and/or hybrid methodologies. The administrative methodology requires that information be reported from administrative databases (claims/encounter data). The hybrid methodology requires that information can be reported from administrative databases and medical record review (MRR). For those measures reported using the hybrid methodology, a nurse, on behalf of CHP, may request Member medical records are supplied for inspection. HEDIS performance measures reported to the State for HMO Members change annually, but generally include the following:

**Effectiveness of Care**

- Childhood immunizations.
- Adolescent immunizations.
- Cholesterol screening & beta-blocker management after myocardial infarction.
- Breast &/or cervical cancer screening.
- Antidepressant medication management.
- Cholesterol management after acute cardiovascular event.
- Comprehensive diabetic care.
- Use of appropriate medications for people with asthma.
- Controlling high blood pressure.

**Health Plan Management**

- Provider network information
- Board certification
- Physician turnover

HEDIS results are reported to the Board of Directors for CHMO. The tools CHMO has developed for the evaluation of participating practitioners during the credentialing process and annually through HEDIS and preventive health studies emphasize the importance of provider preventative services to our members.

**D. HMO Member Participation in Quality Improvement Activities**

At least annually, CHMO contracts with an NCQA certified agency to conduct a consumer survey of a representative sample of Members. The survey includes requests for an evaluation of their Provider(s) and their office(s), the care they have received and complaints and/or suggestions for improvements. It also contains a follow-up mechanism for feedback to the Member, if so desired. The results of these surveys are shared with the CHMO Board of Directors. The results are evaluated to identify areas of opportunity and are reported as part of the HEDIS numbers for CHMO that are available for review by our customers.

CHMO meets quarterly with group representatives to seek input on ways to improve the Health Plan operations and/or Benefits. Members can also informally provide input to CHMO by calling Member Services.

# V. Limitations/Exclusions

## A. Plan Limitations and Exclusions

Participating Providers should use their best efforts to provide services and benefits within the limitations of available facilities and personnel. For verification of benefits covered under the Member's plan, please visit www.coxhealthplans.com first, or then contact Cox HealthPlans' Member Services Department at (417) 269-2900 or (800) 205-7665.

## B. Point of Service (POS) Information

A Member enrolled in the Point of Service (POS) rider has the option of seeking covered services from non-network Providers. POS Members need not obtain referrals for most services sought outside of the network unless indicated in their member handbook or included in the authorization table herein.

When electing to use this Rider, the Member will be responsible for the payment of a deductible, co-insurance and any amounts over Usual and Customary for the service. The same financial exposure results when POS Members seek care from an in-network Provider without having obtained a prior authorization for those services requiring prior authorization. Out-of-network coverage amounts are subject to yearly and lifetime maximum payments by CHMO.

The services and benefits that follow are covered only by the HMO contract to which a POS Rider is attached and are not available to a member from a non-network Provider.

1. Preventive Services (except as identified in the POS rider).
    a. Routine physicals (except gynecological exams).
    b. Immunizations.
    c. Physician office visits and laboratory tests associated with preventive checkups for children.
    d. Flu shots and pneumonia vaccine.
2. Chiropractic Care.
3. Home Health Care.
4. Hospice.
5. Voluntary Sterilization Services.
6. Transplant Services.
7. Outpatient Prescription Drugs.
8. Outpatient Dialysis.

# VI. Prescription Drugs

## A. The CHP Formulary

The Cox HealthPlans' formulary was developed to provide a basis for rational, cost-effective drug therapy. Unless otherwise noted, all dosage forms and strengths of a formulary drug are included.

Considerations in selecting drugs for inclusion in the formulary include:

- Safety relative to other drugs with the same indication and therapeutic action;
- Efficacy of the drug for FDA approved indications;
- Cost relative to other drugs with the same indication and therapeutic action; and
- Available dosage forms of the drug and the dosing interval for each approved product.

A link to the CHP formulary is available on the provider section of www.coxhealthplans.com

**Please also note there is a separate formulary for members receiving benefits through a qualified Metal Plan.**

## B. Use of Generic Products

All Cox HealthPlans' member policies require mandatory generic drug utilization as the first line of prescription treatment. Members will incur fewer out-of-pocket expenses when obtaining a generic product, if available. If the Provider or the member request a brand name medication when there is an FDA "AB" rated Generic available, the member will be charged the applicable coinsurance/copayment of their plan PLUS the difference in the price of the brand name medication and the available generic. This is also referred to as a DAW (Dispense As Written) penalty.

## C. Formulary vs. Non-Formulary

Providers are encouraged to use the drug formulary when prescribing medicine for CHP Members. Choosing formulary products will reduce the patients' out-of-pocket expenses. Participating pharmacies may contact Providers or Cox HealthPlans' Pharmacy Benefit Manager (PBM), when faced with a non-formulary product for suggestions regarding formulary alternatives. Inclusion of a drug in the PBM's formulary does not indicate that the drug is automatically a covered benefit.

A branded drug not listed in the formulary should be considered non-formulary and the Member would be responsible for the cost of the prescription. When a commercially available product is listed in the formulary, all dosage forms and strengths are covered, unless a specific dosage form is listed. All generic medications are available to the Member at the lowest available co-pay, unless specifically excluded from coverage. PPO members may also be subject to pharmacy deductibles per their individual benefit plan.

## D. Drug Coverage Authorization Requirement

Inclusion of a drug in the Pharmacy Benefit Manager's (PBM) formulary does not indicate that the drug is automatically a covered benefit. Coverage is determined by the specific terms of each Member's Evidence of Coverage (EOC) prescription policy at the individual drug level. For drugs requiring prior authorization, please request via the

Authorization Form (Appendix B) contained in this Manual. Visit www.coxhealthplans.com for the most current information. If further information is needed, please contact the pharmacy benefit manager or the specialty drug provider at the phone numbers listed on the website.

## Formulary Drug Edits

Below is a list of the various edits associated with some drugs on the formulary as well as a brief definition.

- **PA (Prior Authorization)- requires review and approval prior to filling**
- **QL (Quantity Limit)- limit on the quantity dispensed for that drug**
- **ST (Step Therapy)- approval subject to trial of preferred alternatives first**
- **AL (Age Limit)- approval of the drug is specific to a certain age range**
- **GL (Gender Limit)- approval of the drug is gender specific**

Note: The following injectable/infusible medications given in the physician office still require preauthorization by CHP and may be requested via the Authorization Form (Appendix B) contained in this Manual: Botox, and Synagis,.

Certain drugs also require prior authorization with the plan.

# VII. Billing Guidelines

## A. General

It is imperative that CHP has accurate Provider billing information on file. Please confirm with your PHO (where applicable) and CHP's Member Services Department that the following information is current in our files:

- Provider name (as noted on Provider's current W9 form)
- Physical location address(s)
- Billing address (if different from physical location)
- Tax Identification Number (TIN)
- National Provider Identifier (NPI)

CHP reserves the right to return any claim where submitted information does not match information currently in our files.

All changes regarding billing information must be conveyed in writing to the appropriate PHO and CHP as soon as possible. TIN information must correlate with what is on file with the IRS; therefore, CHP requests that notification of NPI/TIN/billing name changes be submitted on an updated W-9 form. Changes to a Provider's TIN and/or address are not accepted when conveyed via a claim form.

**Required Billing Forms**

CHP requires the use of standardized paper claim forms, unless the Provider is billing electronically (see sub-section D under this Section for information on electronic claims submission). Claims for hospital-based inpatient and outpatient services and home health services must be submitted on a UB04 form. Claims for Durable Medical Equipment and all professional services (including Provider office visits and services) must be billed on a CMS-1500 form.

**Minimal Data Elements**

All claims must be submitted with the following minimal data elements to be eligible for consideration:

- Date(s) of service
- Bill type (for UB92 claims)
- Member name and 11-digit Member identification number
- Referring/attending Provider name (when applicable)
- Servicing Provider name and credentials
- Billing Entity name, address and TIN (i.e., the entity to be reimbursed)
- Place of service
- Diagnoses (to ultimate specificity)
- Patient account number
- Billed charges
- Location codes
- Procedure codes, for CMS-1500 claims, CPT-4 or HCPCS codes; For UB92 claims, Revenue codes and CPT-4 or HCPCS codes and when applicable, ICD-9 CM procedure codes

- Modifiers (when applicable)
- Admission and discharge status (when applicable for UB92 claims)
- Condition, occurrence, and value codes (when applicable for UB92 claims)
- DRG codes (for inpatient UB92 claims)

**Required Billing Codes**
CHP requires the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. Professional claims must be submitted with CPT-4 and/or HCPCS procedure codes following CPT-4 correct coding guidelines. Institutional claims must be submitted with Revenue Codes and CPT-4 or HCPCS codes and, when applicable, ICD-9 procedure codes.

In addition, written descriptions, itemized statements and invoices may be required for specific types of claims.

**Billing and Method of Payment**
Participating Providers must bill CHP on a standard CMS-1500 or UB04 form within one hundred and eighty (180) days from the date of service, as specified within RSMo 376.384.1. Claims received after one hundred and eighty (180) days from the date of service will not be reimbursed except in instances when CHP is the secondary carrier. In such cases, secondary claims should be filed manually with a copy of the primary carrier's Explanation of Benefits (EOB) within one hundred eighty (180) days of the date of the primary carrier's EOB.

**Receipt of Claim**
Within thirty (30) processing days after receipt of a paper claim, CHP will send an acknowledgment of receipt of the claim. Within one (1) working day after receipt of an electronic claim, CHP will send an acknowledgment of receipt of the claim. Should CHP pay a claim prior to the thirty (30) processing days, payment shall be deemed as acknowledgment of the receipt of claim, as specified in RSMo 376.383.1.

**Corrected Claims**
CHP does not accept hand-written corrections to system-generated claims – particularly those corrections that directly effect or alter benefits, reimbursement or eligibility. All necessary modifications for the purpose of correction must be generated by the Provider's billing system and submitted as follows:

- ***Professional Claims:*** Must be stamped/marked "Corrected Claim." Any changes that effect reimbursement, benefits or eligibility must be accompanied by supporting documentation (i.e., office notes, operative report, etc.). CHP does not accept professional claims electronically.
- ***Facility Claims:*** Must be indicated as "Corrected Claim" by the digit "7" in the final position of the type of bill. Any changes that effect reimbursement, benefits or eligibility must be accompanied by supporting documentation (i.e., office notes, operative report, etc.). CHP does not accept facility claims electronically.

***Electronic Claims: CHP does not accept "Corrected Claims" electronically.*** **Note:** Medical records may be requested to substantiate corrections on a claim. Supporting

documentation is not required for information added to an original claim for the purposes of clarification (i.e., description of service for an unspecified code).

**Time Limits - Timely Filing**
Written proof of charges upon which a claim could be based must be furnished to the Plan within ninety (90) days after the end of the year in which the charges were incurred. Written proof must be submitted as indicated in Appendix E.

**Time Limits - Reconsideration**
CHP will consider claim adjustments, corrections, and requests for review up to one (1) year following the initial claim payment/denial date. Records must be submitted to CHP within one (1) year of the suspended date or the claim will be denied. CHP will be able to resume processing these claim(s) upon receipt of the requested information. A request for a review or reconsideration by Provider must be submitted in writing to the Claims Department. The one (1) year reconsideration limit does not apply to cases of fraud or misrepresentation by CHP or Provider.

**Returned/Reissued Checks**
If you receive a check for payment on multiple accounts, and some of the accounts were processed incorrectly, please do not return the entire check to CHP. Instead, notify the CHP Member Services Department of the specific issue (i.e., insufficient payment, no record of Member, etc.), and CHP will initiate the appropriate review to correct the claim. Returning the entire check only results in delayed postings to those accounts paid correctly.

**Billing HMO Members**
For HMO Members, Missouri Law (RSMo 354.606.5) specifies, "In no event shall a participating Provider collect or attempt to collect from an enrollee any money owed to the Provider by the health carrier nor shall a participating Provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles." As a matter of professional courtesy, as well as regulatory and contractual compliance, do not bill CHMO Members for claims in process or involve the Member in billing problems. The HMO Member should be held harmless during any period of Provider dispute. Members may only be billed for deductibles, coinsurance, non-covered benefits and denials made due to lack of Member response (i.e., COB inquiry, workers' compensation inquiry, etc.).

**Billing PPO Members**
Providers shall not bill Members for health services if the Provider fails to submit claims in accordance with the Provider contract provisions.

**Overpayment**
CHP routinely corrects erroneous payments through the practice of automatically deducting overpayments from future reimbursement.

## B. Professional Billing Information

**Billing for Physician Extenders**
Physician Extenders include, but are not limited to, Nurse Practitioners, Certified Registered Nurse Anesthetists and Physician Assistants acting within the scope of their licensure.

The Physician Extender should bill non-medically directed covered services rendered by a Physician Extender. The Supervising Provider, with the appropriate Physician Extender modifier, should bill for medically directed services.

**Use of Unspecified Codes**
CHP discourages the use of non-specific CPT-4 or HCPCS codes (i.e., CPT-4 codes that end with "-99" or description of "unspecified" or "unlisted"). Should a Provider require the use one of these codes, because no other code is applicable, additional documentation in the form of a written description or attached medical records must be submitted with the claim or the claim payment will be suspended.

**Modifiers**
All claims submitted with modifiers 62, 66, 77, and 78 must be accompanied by substantiating medical records, or they will be pended for additional information.

No additional reimbursement will be paid on modifier 22 without substantiating medical records.

**Bilateral Surgery**
Bilateral surgery means the same procedure performed on both sides of the body. A surgery only qualifies as bilateral if the patient anatomically has two of body part, i.e. ears, eyes, knees, ankles, etc., and the procedure is performed on both parts. A lesion on the right arm and a lesion on the left arm would NOT qualify as a bilateral surgery (the skin qualifies as one body organ). CHP uses the Medicare standard for submission of bilateral surgery charges. Charges for bilateral surgery should be submitted on one service line with the total charge for the bilateral surgery and a modifier of –50.

**Medical Supplies**
Generally, supplies and materials provided in the Provider's office (e.g., syringes, gauze, tubing, etc.) are included in the payment for the office visit or procedure. CHP will reimburse Providers for surgical trays for qualifying procedures only. Surgical tray charges should be billed with the appropriate HCPCS code. The non-specific CPT-4 code 99070 is never reimbursable without supporting documentation.

**Injection/Infusion Services**
Providers should use CPT-4 codes if they are accurate representations of the drugs and dosages being administered. When accurate CPT-4 codes are not available, Providers should use specific HCPCS codes. If accurate CPT-4 or HCPCS codes are not available, or if the drug and dosage administered do not exactly match that of the description, submit J3490 (Unclassified Drugs), along with a written description of the drug and the exact dosage.

**Anesthesia**
Pre- and post-anesthesia consultations or evaluations are generally considered part of the global anesthesia reimbursement. For special circumstances (i.e., cancelled surgery), the consultation or evaluation should be billed with the appropriate modifier and supporting documentation.

Claims should be submitted with the appropriate CPT-4 code for the procedure, as well as any appropriate modifiers and qualifying circumstances (risk factors). Time should be indicated in anesthesia units in the "Units" field of the HCFA-1500 (Box 24, G). Anesthesia units are calculated as one (1) unit per 15 minutes of anesthesia administration rounded up to the next unit.

**Obstetrical Care**
For global maternity care, when a Member has been effective with CHP for nine (9) months or longer, please bill with the appropriate global maternity code.

Global maternity codes include reimbursement for the following services:
- Prenatal care (office visits by Provider or one or more partners)
- Lab work related to pregnancy (venipunctures and urinalysis only)
- Delivery (vaginal or cesarean)
- Post-partum hospital visits
- Post-partum office visits (anytime during the six (6) weeks following delivery)

For maternity care, when a Member has been effective with CHP less than nine (9) months, please bill with the appropriate CPT-4 code that reflects the period of care as specified in CPT-4 coding standards.

## C. Institutional Billing Information
Facilities must bill on a standardized UB04 form using both Revenue codes AND applicable CPT-4 and/or HCPCS codes. All individual dates of service must be itemized on the UB04, in box 45, when billing for multiple dates of service, except for Emergency Room, Observation Room and Inpatient services. Additionally, all applicable fields on the UB92 should be completed in compliance with CMS guidelines. Incomplete claims may result in delayed payment or be suspended for additional information.

CHP follows Medicare billing guidelines regarding required information. Required information is applicable to claims for Members of all plans unless otherwise noted.

## D. Electronic Submission of Claims
CHP contracts with TriZetto EDI as its electronic claims submission clearinghouse. To confirm the availability of this service for a particular provider-type, as well as obtain complete filing instructions, please call TriZetto, Linda Sheer at 1(800) 969-3666 ext.1219. For those Providers already submitting electronically, or anticipating submitting claims electronically in the future, please follow these guidelines.

Submit:

- The patient's CHP Member number, full name, gender and date of birth
- Current diagnosis codes to the highest level of specificity as well as CPT-4, HCPCS,
- and/or Revenue codes, including modifiers where applicable
- Complete dates of service including beginning and ending dates of service (i.e., 01012001)
- Separate claims for each calendar year
- Separate claims for different places of service (CHP follows Medicare guidelines)
- Actual charges
- CHP-assigned Provider number and billing information (payee) numbers

**E. Coordination of Benefits (COB)**

CHP will administer COB provisions based upon Federal and Missouri State regulations, as well as recognized industry standards. For information regarding COB, contact Member Service Department.

**Authorization Requirements When CHP is Secondary**

For purposes of this Section, "authorization requirements" refers to the prior authorization requirements and network limitations of CHP benefit plans.

All authorization requirements that apply to CHP benefit plans as the primary carrier, additionally apply to CHP as the secondary carrier.

As the secondary carrier, CHP will reimburse the lesser of: a) the amount CHP would have paid as the primary carrier OR b) the amount of Member responsibility left after the primary carrier payment. CHP will not pay for services that are determined not to be the Member's responsibility by the primary carrier (i.e., the difference between charges and contract allowables, denials determined to be Provider responsibility, etc.).

## F. Remittance Advice (RA)

After your claim is processed, CHP will provide your office with a Remittance Advice (RA) form outlining any payments or denials in accordance with the Member's coverage and the Provider's contract in force at the time of service.

Each Member's claim is indicated as a separate entry on the RA. The following numbers correspond with the information on the RA.

1. Line of Business: Cox Health Systems Insurance Company, Cox Health Systems HMO, Inc., LE Cox Medical Centers Employee Health Plan.
2. Date: Check/RA run date.
3. Provider name and address.
4. TIN: Vendor (payee) TIN.
5. Patient Name.
6. Insured's name.
7. Age: Patient's age.
8. Patient ID: CHP ID number.
9. Acct: Patient's Account number with Provider.
10. Claim #: CHP Control/claim number.
11. Service Date(s): Date of service.
12. Proc #: CPT codes billed by the Provider.
13. Total billed: Total amount billed by Provider.
14. Amount Allowed: CHP allowable amount based upon contracts and UCR.
15. Prov Resp: For participating providers or wrap network providers this is the difference between the Billed and Allowable amounts or denied amounts based upon bundling, incidental or mutually exclusive services.
16. Interest: Interest paid on unpaid claims based upon the Missouri Department of Insurance statutes and guidelines.
17. Pt's Copay / Pt's Ded / Pt's Coins: Patient responsibility for Copay / Deductible / Coinsurance (when applicable).
18. Total Payment: Total amount paid to provider.
19. See Remarks: Reason/Explanation code.
20. Claim lines billed (including codes).
21. Remarks: Reason / Explanation code details.
22. Summary: Amount Paid – Advance/refund for overpayments = Check Amount.

CHP will pend claims and request additional information from the Provider or Member (i.e., operative notes, Worker's Compensation response, etc.) as needed.

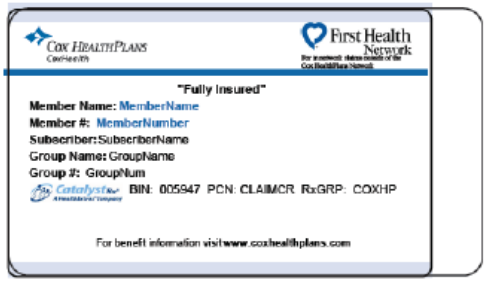
# Appendix A

## Sample Member ID Cards

Front of card Back of card

### Cox Health Systems Insurance Company

#### Employer Group Health - PPO



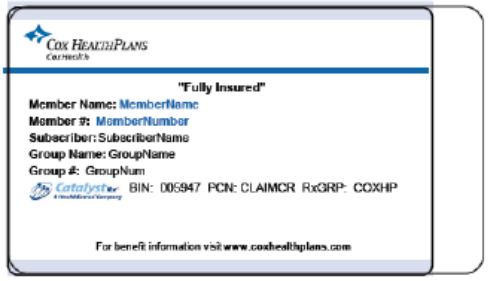


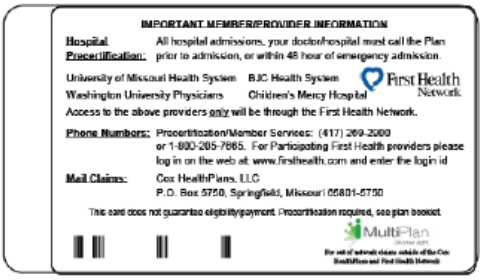
#### Individual Health - PPO



### Cox Health Systems HMO, Inc.

#### Employer Group Health - HMO




### L.E. Cox Medical Center Employee Health Plan

#### Employer Group Health


# Appendix B

## Medical Department Forms

The following forms can be completed electronically within this file and printed for submission, or obtained on our website at http://www.coxhealthplans.com/pages/provider_forms.

- Medical Services Authorization Form
- Catamaran Prior Authorization Form

Feel free to print and copy these forms for completion as needed.

## AUTH FORM MUST BE COMPLETED PRIOR TO EVERY SERVICE REQUEST

| **Today' s Date:** | **Contact Person:** **Phone:** |
|---|---|

***FAX NUMBER(S) TO RETURN AUTH: 1.*** ***2.***

## 1. PATIENT INFORMATION

| **Patient: Last : First: Middle:** | **DOB:** | **Sex:** ☐ **M** ☐ **F** | ***11-Digit*** **Patient Insurance ID #:** __ __ __ __ __ __ __ __ __ __ __ |
|---|---|---|---|

## 2. SERVICE REQUESTED

| **Referring Provider:** | **Phone #:** **Ext.#:** |
|---|---|

**Service Type: Outpatient___ 2. Inpatient___3. Home Health___ 4.DME/Orthotic/Prosthetic ___5. Other___**

## 3. Provider of Service

| **Hospital/Facility/or Servicing Provider :** | **Phone #:** **Ext.#:** |
|---|---|

***Physical*** **Address (If different from Billing address, include both)**:

| **City:** | **State:** | **Zip Code:** | **Servicing Provider Billing Id Required):** |
|---|---|---|---|
| **Admission Date:** | **# of Days/Units Requested:** | **Start Date:** | **End Date:** |

**Diagnosis (ICD-9 Code) With Description (Required):**

**Procedure Code (CPT Codes) With Description (Required):**

## 4. COX HEALTHPLANS USE ONLY

| **Authorization #:** | **Start Date:** | **End Date:** | **Service (s) Authorized:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*****PLEASE NOTE THAT CLINICAL IS DUE ON THE LAST APPROVED DAY. AN AUTH FORM IS REQUIRED FOR ALL NEW OR CONTINUED REQUESTS.***

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

# PRIOR AUTHORIZATION FORM

## COMPLETE AND FAX TO CATAMARAN™ AT 888-852-1832

| MEMBER INFORMATION | | | |
|---|---|---|---|
| **First Name** | | **Last Name** | |
| **Plan** | | | |
| **Member ID** | | **Date of Birth** | |

| DRUG INFORMATION | | | |
|---|---|---|---|
| **Drug Name** | | | |
| **Quantity** | | **ICD-9** | |
| **Directions** | | **Duration of Therapy** | |
| **Diagnosis** | | | |

**PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.**

**Medication/Failure Reason:**

**IgE:_____ TB test result: __Pos / Neg__ Active infection:__ Y / N___ TB treatment:___Y / N ____**

**ESR:_____ CRP:_____ # Joints:_____ %BSA:_____**

**Height:_____ Weight:_____ BMI:_____**

**HA1C:_____ Hemoglobin:_____ Hematocrit:_____ T-Score:_____**

**Dialysis:_____ Long Term Care Facility:_____ Self Injecting:_____**

**Stimulation test:_____/_____ Growth velocity:_____ #Chemotherapy cycles/month:_____**

**Mini-Mental Status Test:_____ Free testosterone: _____/_____Total testosterone_____/_____ Range:_____**

**HCV RNA viral load:_____ Viral Genotype:_____ ALT:_____**

| PHYSICIAN INFORMATION | | | |
|---|---|---|---|
| **Physician Signature** | | **Date** | |
| **Physician Name** | | **NPI #** | |
| **Phone Number** | | **Fax Number** | |
| **Action Needed** | Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function<br><br>☐ Urgent ☐ For Review | **Pharmacy Fax** | |

## INSTRUCTIONS FOR COMPLETING THE APPEAL FORM

**Plan Participant and Prescription Information:**

- Enter the Plan Participant ID number (located on the front of your medical/prescription ID card).
- Provide the date the Adverse Determination occurred.
- Enter the Plan Participant's first name, middle initial, last name and current home address.
- Enter the Plan Participant's date of birth in the box labeled DOB.
- Enter the Plan Participant's home telephone number, including area code.
- Indicate the following medication information if applicable: medication name, medication strength, and medication dosage.

**Physician Information:**

- Specify the prescribing physician or health care professional by both first and last name.
- Enter physician's office location: address, city, state, and zip code.
- Enter physician's office telephone number and fax number, including area code.

**Pharmacy Information:** (if applicable)

- Enter the pharmacy where your medication was filled or requested.
- Enter the location of the pharmacy: address, city, state, and zip code.
- Enter the pharmacy's telephone number, including area code.

**Documentation and Reason for Appeal:**
In the space provided, write an explanation/reason for the appeal and **attach all medical records that support your request for an appeal.** Note: Appeals without medical records attached will not be processed.

- **Urgent Care Declaration:**
- If the claim meets the definition of an urgent claim under the law, specify that the claim is urgent and, if required, provide an explanation.

**Signature of Plan Participant or Provider or Representative:**

- Please sign and date the form to indicate your approval to research this Appeal.

---

**Mail completed form and supporting documents to:**

**Cox HealthPlans Attn: Medical**
**P.O. Box 5750**
**Springfield, MO 65801-5750**

**Or fax to:**
**1-888-200-5230**

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# Catamaran APPEAL FORM

(Please read the Instructions For Completing The Appeal Form)
**Please note that appeal requests will NOT be reviewed without medical records**

**Cox HealthPlans Attn: Medical**
**P.O. Box 5750**
**Springfield, MO 65801-5750**
**Fax Number 1-888-200-5230**

| PLAN PARTICIPANT & PRESCRIPTION INFORMATION | | |
|---|---|---|
| **Plan Participant ID Number** | | **Date of Adverse Decision (Denial)** |
| **Plan Participant Name First** | **Middle** | **Last** |
| **Address** | | |
| **City** | **State** | **Zip Code** |
| **Plan Participant DOB** | **Telephone Number** | |
| **Medication Name** | **Medication Strength** | **Medication Dosage** |

| PHYSICIAN INFORMATION | | | PHARMACY INFORMATION | | |
|---|---|---|---|---|---|
| **Physician Name First** | | **Last** | **Pharmacy Name** | | |
| **Address** | | | **Address** | | |
| **City** | **State** | **Zip Code** | **City** | **State** | **Zip Code** |
| **Office Telephone #** | | **Office Fax #** | **Pharmacy Telephone #** | | |

**Explanation/reason for the Appeal and/or related clinical material** (Please attach additional sheets if necessary.)

**Urgent Care Declaration. An urgent situation is one where denial of care (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims are entitled to expedited review under the plan.**

**If you believe this claim is urgent, please check one of the following below:**

☐ I attest that I am a physician with knowledge of the Plan Participant's medical condition and have determined that this claim involves urgent care.

☐ I am not a physician, but I believe that the Plan Participant's claim involves urgent care because (describe in the space below and attach additional sheet if necessary):

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| **If you do not check one of the boxes above and provide an explanation where required, your claim will not be considered an "urgent care" claim and will not receive expedited review.** | |
|---|---|
| ***Internal Use Only*** | |
| DATE APPEAL RECEIVED | TYPE OF APPEAL<br>❑ Quantity Limits<br>❑ Step Therapy<br>❑ Non-FDA Approved Diagnosis<br>❑ Non-Covered Drug<br>❑ Other |
| APPEAL TECHNICIAN | |
| DATE ACTION TAKEN | APPEAL DECISION |
| DATE OF RESOLUTION | |
| DATE ENROLLEE NOTIFIED | |
| FOLLOW UP/ NOTES | |

***Signature of Plan Participant or Representative*** **X**_____ **Date:** _____

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# Appendix C

## Case Management Services

**Cox HealthPlans wants to help you!**

Welcome to Cox HealthPlans. We are privileged to partner with you for your health care needs. To help you with your personal health needs we have a team of registered nurses who are able to help you coordinate your care within the Cox HealthPlans network. If you, or your insured dependents, have one of the following please consider letting us help you coordinate your health needs:

- Serious ongoing condition (chronic disease)
- Complex health needs with multiple conditions
- Serious operation in near future
- Need of lowering out of pocket cost for prescription medicine

Our Case Management nurses are available to assist you, and your doctor, to obtain needed medical services, providing the highest quality of care with the lowest possible out of pocket cost. If you would like one of our Case Management nurses to contact you, please complete the information below. **Case Management services are considered part of your benefits and are provided at no cost!**

You can send this form to us via fax (417) 269-2919 or, call Member Services at (417) 269-2900 or (800) 205-7665 or mail to the address below. We look forward to helping you!

Daniel O'Connell
Director of Medical Management Cox HealthPlans

**Your Name** _____

**Most convenient way to reach you by phone during business hours of 8:00 a.m. to 5:00 p.m.**
**Home:** _____ **Cell:** _____ **Work:** _____
**or by email:** _____

- ☐ I would like a nurse Case Manager to help me or one of my dependents with one of the items above.
- ☐ I would like a nurse Case Manager to help me with: _____
- ☐ I have had over three hospitalizations in the last year.
- ☐ I have had over three Emergency Room visits in the last year.
- ☐ I would like information about lowest cost pharmacy drugs or how to lower my out of pocket pharmacy cost.
- ☐ Other: _____

# Appendix D

## Provider Selection Standards

| Click on the Link, the Company Name or Product Line for the related Provider Directory. | |
|---|---|
| **Cox Health Systems Insurance Company** *http://www.coxhealthplans.com/providers* | **PPO Group Health** |
| | **PPO Individual Health** |
| | **LE Cox Medical Center Employee Health** |
| | |
| **Cox Health Systems HMO, Inc.** *http://www.coxhealthplans.com/providers* | **HMO Group Health** |

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# Appendix E

# Contact Information

You may contact the departments listed below between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

| **CHP Member Services** | **CHP Medical Management**<br>Please phone, fax or mail all prior authorization forms and responses for medical necessity documentation. |
|---|---|
| Phone: (417) 269-2900 or 1(800) 205-7665<br>Address: Cox HealthPlans, LLC<br>Attn: Member Services<br>P.O. Box 5750<br>Springfield, MO 65801-5750 | Phone: (417) 269-2813 or 1(800) 205-7665<br>Fax: (417) 269-2919 or 1(888) 200-5230<br>Address: Cox HealthPlans, LLC<br>Attn: Medical Department<br>P.O. Box 5750<br>Springfield, MO 65801-5750 |
| | |
| **Provider Appeals** | **CHP Claims Department**<br>Please mail paper claims to: |
| Fax: (417) 269-2949<br>Address: Cox HealthPlans, LLC<br>Attn: Provider Appeals<br>P.O. Box 5750<br>Springfield, MO 65801-5750 | Address: Cox HealthPlans, LLC<br>Attn: Claims Department<br>P.O. Box 5750<br>Springfield, MO 65801-5750 |
| | |
| **Electronic Claims** | |
| Gateway EDI<br>1(800) 969-3666 ext. 219<br>Linda Sheet, Payer Analyst<br>Lsheer@GatewayEDI.com | |