# Community Health Direct Provider Manual

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# Section 1. Welcome and Contact Information

## I. Welcome to Community Health Direct

We are pleased to welcome you to Community Health Direct network (CHD). CHD contracts on behalf of nearly 4,000 physicians, hospitals, and ancillary providers. We serve the greater Indianapolis area including, but not limited to, Anderson, Franklin, and Kokomo areas. At CHD, we are committed to maintaining and enhancing the quality of care for each patient we serve. By reducing cost and overhead, this allows CHD to provide a more effective and efficient network to providers and the communities we serve. In addition to the Direct network, we can assist you in contracting with other payer networks through our Community Health Access agreements.

### Mission, Vision, and Values

Our mission at Community Health Direct not only is to put patients first while offering a full continuum of healthcare services and world-class innovations. Our vision for our providers and members is simple: ***exceptional care, simply delivered.*** These values set Community Health Direct apart and make Community Health Network a leading not-for-profit healthcare destination in central Indiana.

### Notice of Privacy Practices

For the entire publication of Notice of Privacy Practices for Community Health Direct, please see eCommunity.com/privacy.

If you have questions about this Notice, think we may have violated your privacy rights or disagree with a decision we made about access to your PHI, you may contact the Privacy Manager, 317-621-6792 or at privacy@eCommunity.com. You may also submit an anonymous complaint by calling 800-638-5071 or online at eCommunity.ethicspoint.com. You may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized if you file a complaint.**

### Non-discrimination Statement

Community Health Network complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Community Health Network does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## II. Community Health Direct Departments

As a contracted provider, you have access to a dynamic team of individuals that will assist you in removing roadblocks in the managed care environment that can result in untimely delays for your office. CHD provides medical management, customer service, claims and eligibility

assistance, and a Provider Relations Department which serves Community Health Network Community PPO, Community HDHP and Community EPO medical health plans.

One unique aspect of CHD is our delegated credentialing agreements with most payers. Through these agreements, we can provide you with one effective date with most payers. This is a critical efficiency for offices as you no longer have to credential your providers with multiple payers.

### How to Contact Us

Contact information for CHD can be found below and on our full-service Community Health Direct website at eCommunity.com/direct.

For on-the-go services, you can connect with CHD by scanning this QR code:

Community Health Direct
Billing/Claim Address:
P.O. Box 704
Columbus, IN 47202

**Electronic Payer ID:** 77153

Customer Service / Claims Questions: 317-621-7565
Provider Portal Questions: 317-621-7581
Toll Free: 800-344-8672
E-mail: CHDProviderRelations@eCommunity.com

### CHD Provider Directories

Community Health Direct provider directories are available on our website at eCommunity.com/direct.

*Separate directories are available for Community Health Direct PPO/HDHP and EPO plans, City of Fishers employees, and Encore Combined.

## III. CHD Provider Portal

Visit our online provider portal at https://secure.healthx.com/chn.provider. Or scan this QR code for direct access.

Check Claims, Eligibility and Authorization Status

Within the portal you can check claims, member eligibility and authorization status, identify multiple claims at one time, check a span of eligibility, and download claims report information. We have real-time prior authorization submissions, and the provider can check on the status of a prior authorization submission online.

# Section 2. Provider and Facility Credentialing and Enrollment

## I. CHD Credentialing Overview

Community Health Direct (CHD) requires that all participating providers become credentialed and recredentialed to remain current and active status within our provider network. CHD uses NCQA and CMS standards as well as both state and federal guidelines and those guidelines are applicable to any licensed medical practitioner, either independent or part of a group, before reimbursement of any services is rendered to our members. All credentialing policies and procedures are reviewed at least annually by the CHD Credentials Committee to ensure continued compliance.

Completion of initial credentialing, along with a recredentialing every three (3) years, ensures that CHD executes and maintains contracts only with current, licensed providers who have demonstrated competency and meet all standards towards the common goal of providing the highest quality of healthcare.

All CHD contracted providers must complete initial credentialing and maintain their current recredentialing status in order to see and treat our members.

## II. Credentialing Process

The initial credentialing process can take anywhere from 90 to 120 days from the time an application is received until the time the provider is fully effective with the payer(s). That period can be shorter or longer depending on a provider's individual circumstances; however, it will not exceed 180 calendar days from the date the application is submitted.

### Providers Who Must Be Credentialed

- MD Doctor of Medicine
- DO Doctor of Osteopathic Medicine
- DPM Doctor of Podiatric Medicine
- DDS Doctor of Dental Surgery
- PhD, HSPP Doctorate, Health Service Provider in Psychology
- NP Nurse Practitioner
- PA Physician Assistant
- CNS Clinical Nurse Specialist
- CNM Certified Nurse Midwife
- CRNA Certified Registered Nurse Anesthetist
- OD Doctor of Optometry
- DC Doctor of Chiropractic
- LCSW Licensed Clinical Social Worker
- LMHC Licensed Mental Health Counselor
- LMFT Licensed Marriage & Family Therapist
- LCAC Licensed Clinical Addiction Counselor
- CGC Certified Genetic Counselor

## III. Initial Credentialing

### To Begin Initial Credentialing

1. CHD complies with Indiana Statute IC 27-13-1-10 by utilizing the application form of the Council for Affordable Quality Healthcare (CAQH) as the application to be processed. Every provider will need to have a current, active CAQH application completed with permissions granted to CHD to be able to view and access the information. For more information, see the CAQH website at https://proview.caqh.org.
2. Visit eCommunity.com/direct and review the information to submit for enrollment and credentialing. The section includes Frequently Asked Questions about enrollment.
3. **Individual providers** should complete and return the following documents:
    a. New Provider Application Checklist
    b. New Provider Enrollment Form
    c. Provider Contracting Questionnaire
4. **Facility/Ancillary providers** should complete and return the following documents:
    d. Facility/Ancillary Provider Application
    e. Facility/Ancillary Contracting Questionnaire
5. Send all requested documentation to CHDProviderRelations@eCommunity.com to be processed. A member of our credentialing team will be in touch within 48 hours to confirm receipt of the information and will advise if any additional information is needed.

Upon completion of the initial credentialing process, the credentialing applicants will be reviewed by the CHD Credentials Committee chairperson to ensure compliance with all applicable standards, policies, and procedures. A list of all applicants will be presented to the CHD Credentials Committee for review and any applicants who do not meet established criteria will be reviewed and discussed individually. CHD policy ensures that objective review occurs as committee members are to omit from making any voting decisions if the member has been professionally involved with the practitioner, feels there is a conflict of interest or feels that the member's judgment has been compromised.

All practitioners will be notified within sixty (60) calendar days of the peer-review committee's decision. All CHD providers have the right to request and receive information upon request regarding the status of their credentialing application. For more detailed descriptions of minimum standards, required credentialing documentation, information to be reviewed during the credentialing process, and more, please view the following policies:

To obtain a current copy of the full policies for Initial Credentialing and Credentialing Information Security send an email request to CHDProviderRelations@eCommunity.com.

## IV. Community Health Direct (CHD) Recredentialing Process

The recredentialing process occurs every 30-36 months (about 3 years) for each applicant and facility. Three months before the recredentialing due date, CHD credentialing coordinators will access the applicant's CAQH application and will reach out to the credentialing contact listed there if additional information is needed. The 36-month recredentialing cycle begins with the date of the initial credentialing decision. NCQA counts the 36-month cycle to the month, not to the day.

If CHD is unable to complete recredentialing for a practitioner within the 36-month time frame, the reason must be documented in the practitioner's file.

This element is not applicable if CHD cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, family leave or a sabbatical, but the contract between CHD and the practitioner remains in place, CHD may re-credential the practitioner upon his or her return. CHD must document the reason for the delay in the practitioner's file.

At a minimum CHD must verify that a practitioner who returns from military assignment, family leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 calendar days of when the practitioner resumes practice, CHD must complete the recredentialing cycle. On the other hand, if either party terminates the contract or there is a break in service of more than 30 calendar days, CHD must initially credential the practitioner before the practitioner rejoins the network.

If a practitioner is given administrative terminations for reasons beyond CHD's control (e.g., the practitioner failed to provide complete recredentialing information), and is then reinstated within 30 calendar days, CHD may re-credential the practitioner if it provides documentation that the practitioner was terminated beyond its control and was re-credentialed and reinstated within 30 calendar days of termination. CHD must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

At the time of recredentialing, the Credentials Committee and/or chairperson of the Credentials Committee will review all applicants to ensure all standards are met as defined in the Recredentialing Policy.

To obtain a current copy of the Recredentialing Policy, please send an email request to CHDProviderRelations@eCommunity.com.

## V. Monitoring of Sanctions, Complaints and Quality Issues

Community Health Direct (CHD) will conduct ongoing monitoring of sanctions, complaints, and quality issues.

The following agencies will be monitored monthly:

- Indiana Health Professions Bureau
- Office of the Inspector General Administrative Sanctions Branch
- Medicare Opt-Out Lists

CHD regularly monitors quality and at the time of recredentialing performs a review that includes member complaints, utilization data, and grievances and appeals that have occurred during the most recent recredentialing cycle. Full details of the quality review process are contained in the policy linked below.

To obtain a current copy of the full policies for Monitoring of Sanctions and Quality Review please send an email request to CHDProviderRelations@eCommunity.com.

## VI. Appeals

Any party to an original hearing may request an appellate review of the recommendation of the hearing committee by an appellate review committee of the Credentialing Committee. Request for an appellate review must be made in writing and either delivered personally or sent by certified mail, return receipt requested, to the chairperson of the Credentialing Committee within ten (10) days after such party's receipt of the written report of the hearing committee. Failure of any party to request an appellate review in a timely manner shall constitute a waiver of the right to an appellate review.

## Composition of Appellate Review Committee

**Members.** The Chairman of the Credentialing Committee shall appoint a three- (3) member committee to serve as the Ad Hoc Appellate Committee within fifteen (15) days after receiving a request for appellate review. None of the members shall have been participants in the hearing before the Hearing Committee or members of the Hearing committee. The Appellate Review Committee shall have no members who actively participated in initiating or investigating the underlying matter at issue, or who had responsibility for making the proposal giving rise to a hearing right, or who are in direct competition with the participation provider for whom the hearing is conducted.

The Appellate Review Committee shall review the hearing record, the findings, conclusions, and recommendations the Hearing committee, and the written statement submitted, if any. The participating provider may submit written materials in support or opposition and, at the discretion of Appellate Review Committee, may be allowed to present oral argument in support or opposition to the appeal. The Appellate Review Committee shall not conduct a hearing de novo unless instructed to do so by the Credentialing Committee.

The Appellate Review Committee may consult with members of the Hearing Committee or Credentials Committee on any matter or issue raised before the Hearing Committee.

**De Novo Hearings.** The Credentialing Committee, on recommendation of the Appellate Review Committee, and for reasons stated by the Credentialing Committee may direct the Appellate Review Committee to conduct a hearing *de novo* in accordance with the provisions of Article VI. Such a directive for de novo hearing may be made if the Credentialing Committee in good faith believes that a de novo hearing is warranted to promote the ends of a fair truth-finding process under all circumstances of the case and the Board shall have the broad discretion of making such a determination.

The Appellate Review Committee shall consider objections to decisions made by the earing chairperson regarding admitting or excluding evidence. However, any decision on the admission or exclusion of any evidence shall be presumed correct and shall be reviewed only for a clear abuse of discretion. If the Appellate Review Committee finds such a clear abuse of discretion, it should state it in its report under Section 5.01(5) for such a finding.

## Report of Appellate Review Committee

The Appellate Review Committee may at any time during its deliberations recommend in a report to the Credentialing Committee that the Board direct the Appellate Review Committee to conduct a de novo hearing for reasons specified in such report. Within thirty (30) days following receipt of the request for appellate review, the Appellate Review Committee shall complete its deliberations unless a de novo hearing has been ordered or a recommendation for a de novo hearing has not yet been acted upon by the Credentialing Committee, submit a written report recommending that the Credentialing Committee act, reject or accept with

modification the recommendation of the Hearing Committee, and the basis of the recommendation. Agreement by a majority of all members of the Appellate Review Committee shall be required for the issuance by the Committee of any finding, conclusion, recommendation, or report under this Section, including without limitation, the recommendation for a de novo hearing. In the event of a de novo hearing, the Appellate Review Committee shall be governed by the applicable procedural provisions of this hearing procedure that would govern the Hearing Committee.

A copy of any report or recommendation of the Appellate Review Committee shall be provided to each party to the original hearing, to the members of the Hearing committee, and to the Credentialing Committee.

### VII. Confidentiality and Reporting

Proceedings held, actions taken, and recommendations made pursuant to the Credentialing Plan shall be treated as confidential. Community Health Direct requires members of any professional review body to maintain the strictest confidence regarding information presented and discussed during the procedures outlined in the Plan. Members of any professional review body conducting a professional review activity must execute a Confidentiality/Conflict of Interest Agreement.

To obtain a current copy of the Confidentiality/Conflict of Interest Agreement please email CHDProviderRelations@eCommunity.com.

All credentialing files are maintained in a secure manner and are found only in electronic formats, applications or databases that fall under Community Health Network IT security protocols and protections. Only necessary Community Health Direct staff members have access to the applications and accompanying documentation.

## Section 3. Role of the Provider

### I. Provider Rights and Responsibilities

As a contracted provider with Community Health Direct (CHD), providers must adhere to certain rights and responsibilities outlined in your CHD contract. For a complete list, please reference your contract as well as this Provider Manual. Providers see the listing of responsibilities of parties for participating providers herein.

#### Responsibilities of All CHD Participating Providers

The responsibilities of the parties are as follows:

- Provider agrees to perform duties which are consistent with the standards of practice of medicine as is conducted in the geographical region in which provider is located.

- Provider agrees that medical services provided will be made available and accessible to members promptly and in a manner which assures continuity of care.
- Provider agrees to cooperate and comply with all Quality Assurance and Utilization Management programs, peer review, external audits, administrative and grievance procedures, rules, and regulations established by the Network.
- Provider agrees to treat all members with respect, dignity, and non-bias.
- Provider agrees to maintain status as a healthcare provider under the Indiana Medical Malpractice Act, I.C. 16-9.5-1-1.
- Provider agrees to comply with all patient access standards as defined by the Network.
- Provider agrees to maintain the confidentiality of Community Health Direct/Access members.
- Provider agrees to coordinate the care of Community Health Direct members with other providers, which includes, but is not limited to, transfer of medical records and communicating findings with other providers to maintain a continuity of care for the member.
- Provider agrees to report relevant patient information with local, state, and federal agencies as mandated.
- Provider agrees to inform patients of any advanced directives when applicable.
- Provider will maintain and review demographic information submitted to support credentialing of the provider and maintain the accuracy of the demographic information.

### Role of Primary Care Provider (PCP)

The role of the PCP is to navigate the care of the patient seeking services. The role of the PCP is to direct patients to the most appropriate level of care, while keeping in constant communication with the specialist, facility or any other providers involved in the care of the patient. The expectation of the primary care provider is to:

- Direct all levels of care for the patient, including but not limited to referrals, prior authorizations and any additional care needed to treat any condition of the patient.
- The PCP agrees to be available to the patient during normal business hours as well as providing after-hours and on-call coverage for any patient seeking services from PCP.
- It is the main responsibility of the PCP to help guide the patient through the healthcare system. PCP will refer Community Health Direct members to in-network levels of care. If no in-network care is available, PCP will work with CHD Medical Management to identify other providers available with proper notification (referral/prior authorization).
- PCP may utilize the Community Health Direct provider portal to check eligibility on any Community Health Direct plan. It is the responsibility of the PCP to verify the eligibility of the member prior to services being rendered.
    - Community PPO, Community HDHP and Community EPO health plans

### Role of Specialty Care Provider (SCP)/Referrals

The role of the SCP is to work with the patient's PCP to author a medical plan that addresses the patient's needs.

- The SCP will treat the member within the scope of service and specialty that the SCP is credentialed with at the Network.
- The SCP will maintain accurate medical record documentation and treatment plans on behalf of the member and communicate any updates or changes with the member's PCP.
- The SCP must provide consultation to other providers/facilities as requested when necessary.
- The SCP will treat the Community Health Direct/Access members with the utmost respect, dignity, and non-bias.
- SCP may use the Community Health Direct provider portal to check eligibility on any Community Health Direct plan. It is the responsibility of the provider to verify the eligibility of the member prior to services being rendered.
    - Community PPO, Community HDHP and Community EPO health plans

## II. Guidelines for Provider Access and Availability

Provider must adhere to the provider access and availability standards outlined in the Provider Manual.

### Appointment Standards

Contracted providers must adhere to the following appointment standards:

**Primary Care Provider Appointment Standards**

| Appointment Type | Waiting time for appointment |
|---|---|
| Emergency | Immediately |
| Urgent/Emergent | Within 24 hours |
| Routine Care | Within 5 business days |
| Preventive Care | Within 30 calendar days |
| After-hours Care | Patient must be able to reach provider 24/7 by answering service, call coverage or instruction on how to reach provider. |

**Specialty Care Provider Appointment Standards**

| Appointment Type | Waiting time for appointment |
|---|---|
| Emergency | Immediately |
| Urgent/Emergent | Within 24 hours |
| Routine Care | Within 5 business days |
| Preventive Care | Within 30 calendar days |
| After-hours Care | Patient must be able to reach provider 24/7 by answering service, call coverage or instruction on how to reach provider. |

**Behavioral Health Provider Appointment Standards**

| Appointment Type | Waiting time for appointment |
|---|---|
| Emergency | Immediately |
| Urgent/Emergent | Within 24 hours |
| Routine Care | Within 5 business days |
| Preventive Care | Within 30 calendar days |
| After-hours Care | Patient must be able to reach provider 24/7 by answering service, call coverage or instruction on how to reach provider. |

## III. Timely Notice of Demographic Changes

Provider agrees to provide Health plan with timely notification of any demographic changes provided within the contract. Changes are to include, but are not limited, to panel open/closure, address change, phone/fax, hospital affiliation changes or any change impacting the original information submitted within the contract with the Network. Health plan shall be notified in ninety (90) days written notification from provider for any demographic or panel status change prior to services being rendered. The Network will then notify the appropriate payers twice a month on behalf of the provider with any demographic changes received. Provider agrees to maintain demographic information with the Network for purposes of directories, referrals, and member directories.

## IV. PCP Termination Timeframes

A primary care provider is responsible for treating members on their panel throughout the termination process for continuity of care for the patient. Whether the care requires treatment, referrals or prior authorizations, the PCP is responsible for the patient throughout the transition. Provider must notify the Network within ninety (90) days in writing with intent to terminate their agreement with Community Health Direct. The provider contract may be terminated by either party at any time by giving at least ninety (90) days' notice in advance to the other party, or by Community Health Direct immediately if:

- Provider's license to practice medicine is suspended, revoked, or limited such that Provider cannot render services and/or dispense drugs without supervision.
- Provider no longer maintains admitting privileges at a hospital that is a participating provider or has such privileges limited in a way that hinders provider's ability to care properly for Community Health Direct members.
- Provider fails to comply with the malpractice insurance provisions within the provider contract.
- Provider makes any material misrepresentations in or omissions from provider's application.
- Provider makes any other material breach of the provider contract.

### PCP Panel Changes

Primary care provider must notify Network ninety (90) days prior to making any changes to their panel of patients. This includes, but is not limited to, opening to new patients, closing your panel to patients, or putting a panel on hold.

### Termination Timeframes

Provider has agreed to adhere to the term and termination sections outlined in their Provider Agreement with the Network. Term and termination sections are no less than ninety (90) days written notice. Please reference the contract for full terms.

## V. CHD Newsletter and Other Educational Resources

Community Health Direct has created an electronic monthly newsletter for contracted providers, facilities, and ancillary vendors. To enroll in the monthly CHD Provider Newsletter, please click here.

### CHD Welcome Letter

Once provider has completed and been approved through the CHD credentials committee meeting, the provider will receive a welcome letter from their assigned Provider Relations Analyst, no later than 10 business days after the approval of the credentials committee. The CHD Credentials Committee meets on the first Friday of each month. The welcome letter also outlines a list of specialized services you receive from our team as a contracted provider. We

urge each provider to schedule a new provider in-service training with your Provider Relations Analyst. Contact information is found in the welcome letter or on the CHD website within the Provider section under Service and Education.

### Provider Payer Grids

Provider payer grids are used to educate providers on all Community Health Direct payer partners, which also captures the effective date by payer, by provider. Your Provider Relations Analyst is responsible for the creation and upkeep of this document. The grids are typically given to practices during your in-service/training. Payer grids are updated on a yearly basis and distributed throughout the first quarter of each following year.

## VI. Provider Online Resources

Providers have a host of online resources available at eCommunity.com/direct. Not only do you have access to the CHD Provider Manual online, but also several other resources and forms:

- Provider directories
- Credentialing and contracting forms
- Requests for additional staff training
- Claims and eligibility checks through our Community Health Direct Provider Portal
- Electronic remittance advise
- Electronic EOBs
- FAQs
- Online prior authorizations
- Change of Information forms

# Section 4. Claims Inquiry and Billing Timeframes

## I. Claims Inquiry and Billing Timeframes

### Claims Inquiry

Providers can check claim processing and payment status on the CHD Provider Portal without having to contact CHD Customer Service. CHD representatives are available for any complex issues or questions regarding payments, checks, overpayments, refunds, or claim processing by calling 317-621-7575 or toll-free 800-344-8672. The CHD Customer Service department can be reached Monday-Thursday from 7:30 a.m. to 4:30 p.m. and 7:30 a.m. to 4 p.m. on Friday.

### Billing Timeframes

Community Health Direct has a filing limit of one year (365 days) from the date of service. If a claim is not received before the year filing limit, it will be denied.

## II. Claims Policies

### Clean Claim Definition

A clean claim is a claim that has no defect, impropriety, or lack of any required substantiating documentation. A clean claim must include:

- Member's CHD ID number (as stated on the member's CHD ID card)-Box 1a
- Member's full name (as stated on the member's CHD ID card)-Box 2
- Member's correct date of birth (as stated on the member's CHD ID card)-Box 3
- Valid diagnosis code(s)-Box 21
- Date(s) of service-Box 24A
- Valid place of service code-Box 24B
- Valid procedure code(s) and modifier(s), if applicable-Box 24D
- Charge information and units-Box 24F & 24G
- Correct diagnosis pointer-Box 24E
- National Provider Identifier (NPI) for the rendering provider-Box 24J
- Provider's federal tax Identification number (TIN)-Box 25
- Vendor name and address-Box 33
- National Provider Identifier (NPI) for the provider's group-Box 33a
- Any Explanation of Benefits (EOB) from a member's primary insurance carrier, if applicable attached to the claim

### Corrected Claim Submission

For a corrected claim submission, providers may submit a new corrected claim within one (1) year or (365 days) of the date of service. '***Corrected Claim***' should be indicated on the paper claim or on a cover letter attached to the paper claim. For submitting electronic corrected claims use HCFA field 19 or 837 Loop 2300 with Claim Frequency Code 7 for adjustment to original claim or 8 for void of original claim. See example below:

CLM*12345678*500***11:B:7*Y*A*Y*I*P~

REF*F8*(Enter the Claim Original Document Control Number)

### Resubmitting Claims

Prior to resubmitting a claim, the claim's status should be checked via the CHD Provider Portal at https://secure.healthx.com/chn.provider or by speaking to a CHD customer service representative at 317-621-7575 (toll free 800-344-8672).

- A claim should only be resubmitted if no payment, remittance advice, or letter requesting additional information has been received within thirty (30) days **and** CHD does not have a record of receiving the claim.

### Subrogation

When it comes to subrogation, CHD operates under the 'Pay and Chase' method. CHD will process any medical claims received regardless of it being an accident or workers' compensation situation. After payment, Optum/Ingenix coordinates recovery of any funds from TPL carriers. If a provider receives a direct payment from a TPL carrier, CHD's original payment should be refunded. (See Refund section below.)

## III. Claims Format for Submission

### Paper Submission

Claims are accepted in CMS 1500 or UB04 format and should be mailed to:
Community Health Direct
P.O. Box 704
Columbus, IN 46202

### Electronic Claim Submission/EDI Clearinghouse Information

CHD's Electronic Payer ID is ***77153*.**

## IV. Provider Payments and Disputes

All correspondence, including refunds, should be mailed to:
Community Health Direct
P.O. Box 50407
Indianapolis, IN 46250

### Overpayments

If CHD discovers an overpayment has been made, within one year of the payment date, (ex: Other Insurance is primary, retro termination of coverage, procedure paid in error, etc.), a refund request will be sent to the provider for the full amount paid on the claim. Once the claim is reprocessed correctly, the correct amount will be paid to the provider. Community Health Network employed physician and facility payments will automatically be reversed and recouped from future payments.

### Refunds

Once a requested refund is received, the claim will be reprocessed correctly within ninety (90) days of receipt. If an unrequested refund is received, the claim will be reviewed to determine if the refund is appropriate. If the refund is appropriate, it will be applied, and the claim reprocessed. If the refund is inaccurate, the money refunded will be sent back to the provider, within ninety (90) days, with an explanation of why the refund is not appropriate.

### Recoveries

If a requested refund is not received within one hundred twenty (120) days of the original

request, the claim will be reversed, and the payment will be recouped from future payments to the provider.

### Balance Billing

Providers who are contracted with CHD (or EncoreCombined or First Health) will be reimbursed at the contracted rate per the provider agreement. CHD members cannot be billed the balance between the contracted rate and the amount charged by the provider. Members also cannot be billed for services that are denied due to provider oversights such as filing a claim past filing limit, no response to request for additional information (from the provider), submitting an incomplete claim or not obtaining a prior authorization on certain services. For a current list of services requiring prior authorization, refer to the document at eCommunity.com/priorauth.

Providers who are not contracted with CHD (or EncoreCombined and First Health) are not required to accept the CHD contracted rate and may balance bill the member. It is the member's responsibility to know what providers are in-network for their health plan.

### Non-Covered Services

Non-covered services are services not covered under the member's health plan. It is the members' responsibility to know what services are not covered. Providers may collect payment from the member for non-covered services. There is a difference between non-covered services and services that require prior authorization. Non-covered services are listed as exclusions on the member's health plan via the CHNw Benefits Planner. However, non-covered services can be deemed payable if documentation is submitted to the Medical Director for review, before services are performed, and it is determined to be a necessary procedure. Services that require prior authorization are listed by procedure code on the CHD website, and the member and provider portals. There is not a list of non-covered procedure codes.

# Section 5. Eligibility, Benefits and Member ID Cards

## I. How to Verify Member Eligibility and Benefits

### CHD Provider Portal

Providers can verify a member's eligibility and benefits can be verified online via the CHD Provider Portal at https://secure.healthx.com/chn.provider.

### CHD Customer Service

A member's eligibility and benefits can also be verified by contacting a CHD Customer Service representative at 317-621-7575 (toll-free 800-344-8672). The CHD Customer Service department can be reached Monday-Thursday from 7:30 a.m. to 4:30 p.m. and 7:30 a.m. to 4 p.m. on Friday.

## II. Copays, Co-Insurance, and Deductibles

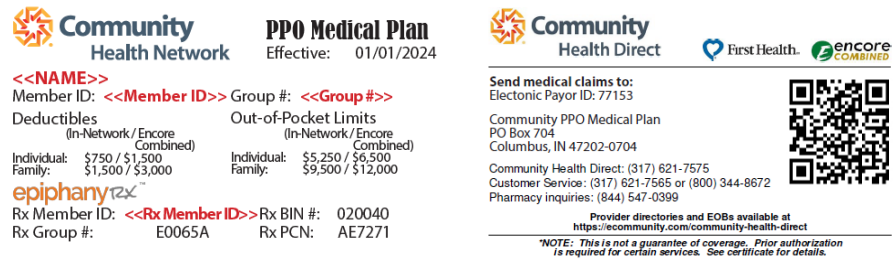
A member's copay (as listed on the CHD Member ID card) is due at the time of service. Any co-insurance or deductible amounts will be calculated at the time the claim is processed. If deductible and coinsurance amounts are verified via the CHD Provider Portal, the amounts can still change between the date of service and the time the claim is received and processed; refunds may be due to the member if deductible and coinsurance amounts change between verification and claim processing dates.

## III. CHD Member ID Cards

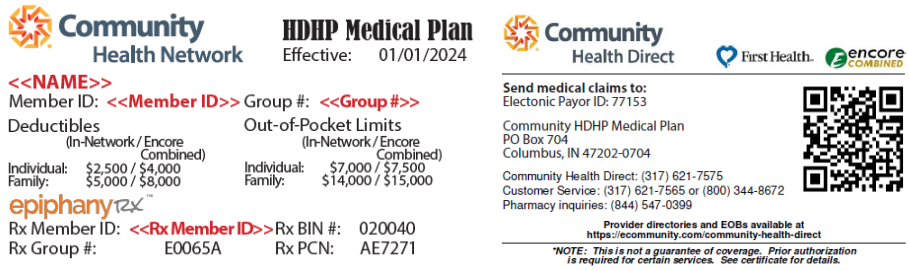
**Eligibility and benefit information should be verified before rendering services. Possession of an ID card does not guarantee coverage or payment.*

### Community Health Direct Patient Cards

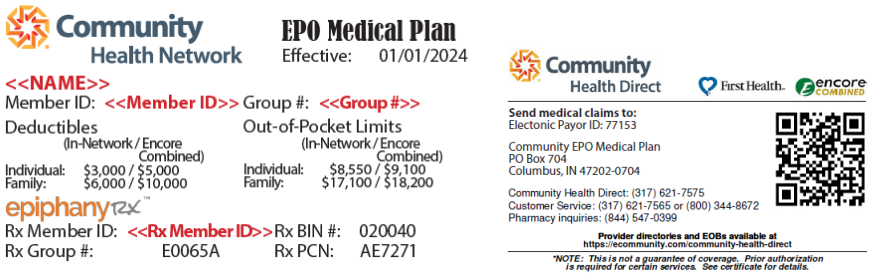
#### Community PPO Plan ID Card



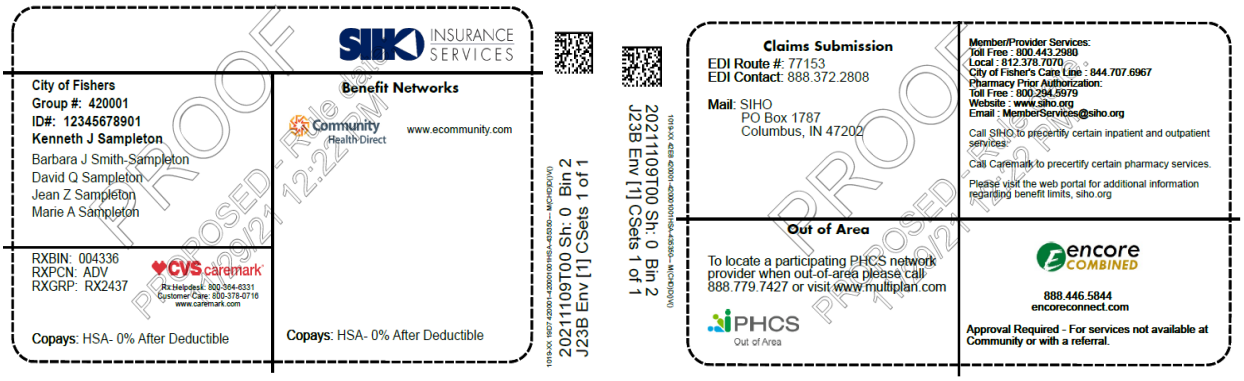

#### Community HDHP Plan ID Card




#### Community EPO Plan ID Card

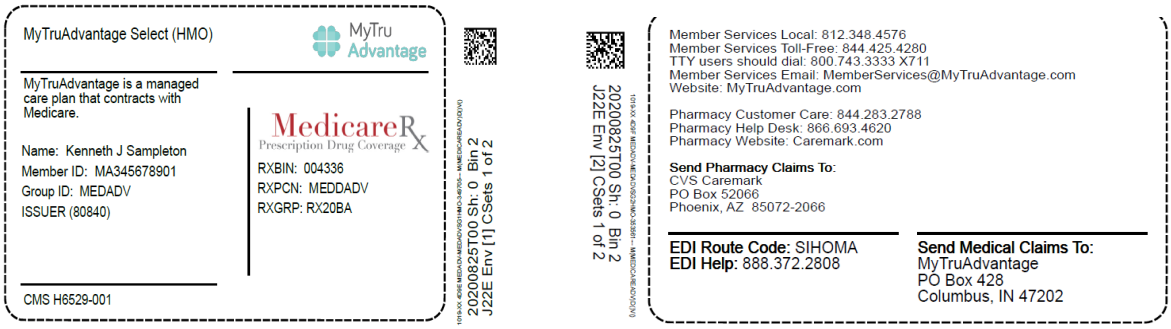


## Community Health Direct City of Fishers Plan ID Card




## Community Health Direct MyTruAdvantage Plan ID Card

MyTruAdvantage is a managed care plan that contracts with Medicare.




# IV. Coordination of Benefits (COB)

## Medicare

**Community Health Direct is primary and Medicare is secondary** if the member is eligible for Medicare ***AND*** is actively working (*or the spouse of an active employee*) in a benefits-eligible status covered under one of our medical plans.

## Commercial

1) *Subscribers* - **Community Health Direct is primary** if the member is the subscriber on the CHD plan ***AND*** a dependent on the other plan or the subscriber on both plans and the CHD plan has been effective the longest.
2) *Dependents* - **Community Health Direct is primary** if the CHD subscriber's birthday is first in the year before the subscriber of the other policy* (a.k.a. The birthday rule), there is a court order (ex: divorce decree) stating that our subscriber is to cover the dependent, there is NO court order, and our subscriber has custody of the dependent, or there is NO court order, and our subscriber is the spouse of the parent with custody of the dependent.

*If the same birthdate, the plan that has covered the dependent the longest is primary.

## V. Appeal Process

Please submit all provider appeals to:
Community Health Direct
Attn: Appeals
P.O. Box 50407
Indianapolis, IN 46250

### Member Appeals

Members may appeal a claim denial by filing a written appeal within one hundred eighty (180) days of receipt of the denial by the claimant. If an appeal is not received in a timely manner (within one hundred eighty (180) days of receipt of the denial), the original denial of the claim is binding, and the claim is deemed denied for purposes of this review. For more detailed information, please refer to **Section 6: Medical Management Member Appeals**.

### Provider Appeals

Providers may appeal a claim denial or reimbursement amount by filing a written appeal within one (1) year of receipt of the denial notice. The appeal should include the reason the provider feels the denial or reimbursement amount is incorrect and any supporting documentation. If after the claim is reviewed it is found that the claim was denied in error, the claim will be reprocessed, and the provider will receive corrected remittance advice. If after the claim is reviewed it is found that the claim was correctly denied or the amount is correct, the provider will receive a letter outlining the reason the denial stands.

# Section 6. Medical Management

## I. Prior Authorizations

### Prior Authorization

Prior authorization, sometimes called precertification or prior approval, is a health plan cost-control process by which healthcare **providers and members must obtain advance approval from a health plan before a specific service is delivered** to the patient to qualify for coverage payment.

### In/Out of Network Prior Authorization Process

As a provider-owned third-party administrator, it is the practice of Community Health Direct to limit prior authorizations to high-cost durable medical equipment, out-of-network services that are available in-network, inpatient admissions, and services where either the utilization by the health plan is significantly greater than the national benchmark and/or conservative management is expected per standards of care. Therefore, the list of services that require prior authorization is revised on a yearly basis, some services may be removed from the prior

authorization requirement while others may be added. The list of services that require prior authorization is maintained within the *Prior Authorization Quick Reference Guide* found at eCommunity.com/authqrg.

All out-of-network services require prior authorization except for emergency and urgent care services. A Community Health Direct participating provider, preferably the member/patient's primary care provider, should submit a prior authorization request form for the out-of-network service. Out-of-network services that are unavailable with a Community Health Direct participating provider will receive approval and coverage at the in-network level.

### Services that Require Prior Authorization (DME, Inpatient Care)

In addition to the *Quick Reference Guide*, a more detailed list of services requiring prior authorization can be found in the *Procedure Codes Requiring Prior Authorization* spreadsheet at eCommunity.com/authcodes.

**Please note this spreadsheet will never be completely up to date due to coding updates and technology advances with new procedures, devices, and medications. If you are requesting a recently developed medical service/supply and/or a potentially experimental one, it may not be found within this spreadsheet. For those situations, please either contact Community Health Direct Customer Service at 317-621-7575 or submit a prior authorization request.

### Obtaining Prior Authorization (Online and Paper) Process

To submit a prior authorization request to Community Health Direct, a Prior Authorization Request form must be filled out completely and submitted to the Medical Management staff, either electronically through the Provider Portal or submitted by fax.

Fill out an **online prior authorization request** through the Provider Portal at https://secure.healthx.com/chn.provider.

**A paper request** may also be completed. Download the form at eCommunity.com/priorauth

Please complete the form in its entirety and fax 317-621-7984. Community Health Direct has up to fourteen (14) days to complete a prior authorization review by accreditation standards, although the plan strives to exceed those standards with completion in 3 business days. For cases submitted with incomplete clinical documentation, resubmission of the prior authorization causes the timeframe to restart.

### Prior Authorization Help

Click here to view/download these materials:

- Prior Authorization Request Form
- Procedure Codes Requiring Prior Authorization
- Prior Authorization Quick Reference Guide
- Steps to Submit Prior Authorizations Online

**Retroactive authorizations** are provided for extenuating circumstances for up to a five (5) day grace period from the date the services were rendered. The retroactive authorizations will be reviewed for medical necessity when received.

## II. Medical Management/Case Management

Medical management/case management by Community Health Direct is performed by applying Milliman Care Guidelines (MCG), other approved medical policies, peer-reviewed medical literature, and national/professional guidelines.

## III. Medical Appeal Process

**Appeals** for denied services or services not paid in full are available for providers and members.

**Member appeals** for reconsideration to change a coverage decision or the amount paid can be submitted in writing to Community Health Direct within one hundred eighty days (180) days of a prior authorization denial notification or a denied claim.

The address for medical plan appeals is

Community Health Direct
Member Appeals
6626 E. 75th Street, Suite 500
Indianapolis, IN 46250

Both prior authorization denial notifications and denied claim letters explain the process for member/patients to submit an appeal. You may also refer your member/patients to the ABC Benefit Planner Appendix section on Legal Information and appeals for more information.

A member/patient may file their appeal on their own or they may have someone act as their healthcare representative on their behalf, including their healthcare provider. In order for a member/patient to have someone else file an appeal on their behalf as their healthcare representative, member/patient must provide Community Health Direct with a written statement that is submitted along with the appeal. The written statement must include:

1. The member/patient's name
2. The member/patient's date of birth
3. The member/patient's health insurance number
4. A statement that explains/names who they are appointing as their healthcare representative for the appeal
5. The member's signature and written date of the statement

**Provider Appeals** for reconsideration to change a coverage decision, or the claim amount paid, the request must be submitted in writing to:

Community Health Direct
Provider Appeals
P.O. Box 50407
Indianapolis, IN 46250

**Please refer to the Eligibility section of this manual on page 25 for more information on Provider appeals.

## IV. Services Not Covered by Community Health Direct or Deemed not Medically Necessary

Payment for these services may be collected directly from the member/patient IF the provider obtains the member/patient's consent before the service(s) are rendered. The member/patient's consent allows them to make an informed decision and must comply with the following:

1. The service to be provided
2. An estimate of the charges for the service
3. The reason you believe the service is not covered or may not be covered
4. Member signature and date before the services are rendered

***Please Note:** A copy of the member/patient's consent must be retained as part of their medical record. As the rendering provider, if you fail to obtain written consent from the member/patient as described above, you may not bill the member/patient.

## V. Case Management

Case management collaborates with members to meet their healthcare needs across the care continuum by coordinating quality health care services and maximizing benefits through a realistic, cost-effective, and timely case management plan. The goal is to optimize health, function, safety, and satisfaction of our member/patient's using advocacy, communication, education and the identification and facilitation of needed services. Referrals for case management services come most often from utilization review personnel, the member/patients themselves, and by provider request (call 317-621-7575).

Case managers, on notification of inpatient facility discharge, contact member/patients within 24 to 48 hours by telephone to resolve any outstanding barriers to the discharge plan and any other resource needs. Members/patients without primary care providers or necessary specialty providers are given assistance in selecting one of their choosing. As needed and/or as requested by member/patients, case managers will arrange three-way calls between the member/patient, the member/patient's provider, and themselves to assist in healthcare education and issue resolution.

Additional case management needs are determined by member/patient assessments through a review of medical history, pharmacy fills, and screenings such as the PHQ-9 or the Boost Assessment. Specific disease management education for member/patients utilizes Disease

Management Zones for self-management and Krames Patient Education materials consistent with Community Health Network.

Case managers refer members/patients to both Community Health Network resources and external resources. Community Health Network referral resources include care navigation, transitional care nursing, Medication Assistance Program, social services, Employee Assistance Program, and crisis and behavioral health evaluations. External resources include the Indiana WIC Program, the Indiana State Department of Health, local/county health departments, and services within the Connect2Help™ Rainbow book.

# Section 7. Quality Management Program

## I. Scope of Quality Management Program

Community Health Direct plans establish and maintain an ongoing program of quality improvement to facilitate continuous improvement of healthcare, clinical education, safety, and services to meet customer needs and expectations and to enhance or improve the health status of Community Health Direct plan members. These efforts support Community Health Direct's mission of providing cost-effective, appropriate, quality healthcare and responsive customer service to members.

## II. Annual Quality Management Program and Plan Description

The purpose of the Quality Management Program at Community Health Direct is to measure and analyze information, gather data about the quality of services of the contracted Community Health Direct providers, identify key processes and areas of service improvement as well as implement those identified improvements to better meet the needs of the Community Health Direct clients, providers, and consumers. The Quality Management Program monitors the Preferred Provider Organization (PPO), High Deductible Health Plan (HDHP) with an HSA and the Exclusive Provider Organization (EPO) to ensure clinical and administrative services provided by Community Health Direct meets regulatory compliance as well as URAC performance standards for Health Utilization Management accreditation.

### Clinical Quality of Care

The Quality Management Program for clinical quality of care issues is conducted under the guidance of the Community Health Direct Clinical Advisory Committee (CAC), which includes participating Community Health Network primary care physicians, specialist physicians, and pharmacists. The Community Health Direct Medical Director serves as chairperson of the CAC.

### Annual Quality Management Plan and Annual Review

Community Health Direct implements an annual Quality Management plan and conducts an annual review to assess the status of compliance and regulatory standards, benchmarks, trends, and variations and to identify opportunities for enhancements for the upcoming year

for the Quality Management Plan. The Clinical Advisory Committee also reviews the Quality Management Program Plan annually for revision to maintain current relevance, accuracy, and accreditation standards. All departments of Community Health Direct participate in the Quality Management Program including Claims, Eligibility, Customer Service, Information Systems, Medical Management, Managed Care Pharmacy, Administration, Finance, Business Information and Provider Relations. The Quality Management Program encompasses the following customers: members, providers, other network partner organizations, payers, and external accrediting agencies.

## III. Regulatory Compliance

The Quality Management Program is designed to comply with the State of Indiana, NCQA and URAC Health Utilization Management accreditation standards and client specific requirements. Community Health Direct will cooperate fully and in a timely manner with delegation oversight activities conducted by the client and will respond to all recommendations within the established time frames. Community Health Direct will maintain compliance with delegation requirements and appropriate accreditation standards.

## IV. Recredentialing of Community Health Direct Providers

The Community Health Direct Quality Management Program provides assistance to the Community Health Direct Provider Relations department by participating in the triannual reaccreditation process for all contracted providers, reviewing for quality metrics for providers with a member panel of fifty plus members and with at least three visits (in person or virtual) within the look back period.

## V. Client, Consumer and Provider Satisfaction

Client satisfaction for Community Health Direct for the services of Medical Management is measured by the quarterly meeting of the Senior Leadership of Community Health Direct. Discussion is focused on analysis of utilization trends, key process improvements, cost projections, and quality initiatives. The results are reported back to the Clinical Advisory Committee on an annual basis.

Consumer and Provider satisfaction is measured by maintaining a log of consumer compliments and complaints. The results are reported back to the Clinical Advisory Committee on an annual basis.

## VI. Quality Improvement Projects

Community Health Direct Quality Program maintains no less than two quality improvement projects that address opportunities for error reduction or performance improvement at any one time. At least one of the two quality improvement projects will address consumer safety for population served and that if the quality improvement project is clinical in nature, the senior clinical staff person will direct and judge the clinical quality measures and clinical aspects of

performance of the quality improvement projects. The results are reported back to the Clinical Advisory Committee on an annual basis.

### VII. Review and investigate Potential Quality of Care Complaints

Community Health Direct Quality Program is tasked with providing clinical review and investigation when potential quality issues are identified by members, providers, other network partner organizations, payers, and external accrediting agencies. Clinical documentation can be requested from providers for review. In addition, providers will be given the opportunity to add any additional information that may be pertinent to the care of the member. This information is held peer protected and is shared with the Community Health Direct Medical Director and if deemed appropriate, the Clinical Advisory Committee for a determination of a Potential Quality Issue. Verified Potential Quality Issues can be shared with the appropriate service line at Community Health Network for further investigation for Community Health Network providers. A copy of the Potential Quality review is placed in the credential file at Community Health Direct.

#### Contact the Quality Department at Community Health Direct

Anne Beck, RN, Quality Manager
Phone: 317-621-7512
abeck@eCommunity.com

## Section 8. Pharmacy Information

### I. Pharmacy Benefits Information

Community Health Direct Partners with EpiphanyRx LLC, a part of Navitus Health Solutions, LLC as the pharmacy benefit manager. All Community Health Direct medical plans include a pharmacy benefit. Specifics related to benefits and network pharmacies may differ between plans.

### II. Preferred Formulary Medication List

Community Health Direct maintains a formulary list that is updated throughout the year. The formulary includes covered medications and their tier as well as additional helpful information. The current list can be found on the CHD website here.

***Use of the Preferred Formulary Medication list:***

| Column | Information |
|---|---|
| Formulary Tier | • Identifies medications as tier 1, tier 2, tier 3, specialty tier, or not covered. This information can be used to compare costs in the benefit plan summary above |

| | |
|---|---|
| | • For some medications, an asterisk (*) may appear with the tier. The (*) denotes medications that are part of the mandatory copay assistance program. Please see the section below on the mandatory copay assistance program for more information<br>• Excluded (EXC) indicates medications that are not on the formulary |
| Value Based Drug # | • Identifies medication available at $0 with a "Yes-$0<br>• Identifies medications available at cost savings with a required copay assistance program with a "Yes*"<br>• Only members on PPO and HPHP are eligible for the savings included in the value-based drug list program<br>• Please see section below on value-based drug list and mandatory copay assistance program for more information |
| Maintenance Drug | • Identifies maintenance medications that are part of the mandatory maintenance drug program with a "Yes"<br>• Please see section below on mandatory maintenance program for more information |
| Prior Authorization | • Identifies specialty and non-specialty medications that require a prior authorization from the providers office with a "Yes"<br>• Please see section below on prior authorizations for more information |
| Step Therapy | • Identifies medications that require step therapy with a "Yes"<br>• Medications that require step therapy require the use of other therapies first before allowing coverage. This is different than prior authorization as documentation from the provider's office is not needed if the patient has a history of filling the other medication. |
| Quantity Limits | • Identifies the maximum amount allowed per time period for the specific medication.<br>o Many quality limits are listed for 30 days. When 90-day fills are allowed, the quantity limit would be 3 times the 30-day quantity limit.<br>• If an amount is needed over the quantity limit, the provider's office may start a prior authorization for the larger amount |
| ACA Drug | • Identified medication on the ACA list with a "Yes"<br>• ACA list medications are available at $0 to the member<br>• A complete list of ACA medications is also available outside of the formulary list and is also found on the website. |

## III. Additional Pharmacy Programs

### Value-Based Drug List

As part of the pharmacy benefit for members with Community PPO and HDHP, there is a value-based drug list. This list includes medications for diabetes, cardiovascular disease, asthma, and COPD at low or no cost to the member. Medications are available at $0 where listed or are available at a discount with the use of a required copay assistance program where identified. (In this case they do bypass the deductible). EPO members are not eligible for the Value-Based Drug benefit.

In addition to being listed in the Preferred Formulary Medication list, all value- based drug medications are also listed together on the Value-Based Drug List found here.

### Required Maintenance Medication Program

All Community plans include a mandatory required maintenance medication program. Within this program, many brands and generic medications used for chronic disease states and identified as maintenance are required to be filled for 90 days at Walgreens or AllianceRx Walgreens Pharmacy. Maintenance medications may be filled for up to three (3) 30-day supplies prior to the need for a 90-day supply to allow for tolerability assessments, dose titrations, etc. If the medication is filled for less than a 90-day supply and /or filled at a non- Walgreens pharmacy after the 3 fills the patient will be responsible for the full cash price of the medication. Medications that require the use of the required maintenance medication program are denoted in the Preferred Formulary Medication list as indicated above.

As a cost savings to patients with the mandatory required maintenance mediation program, when filling a 90-day supply, the patient will pay 2.5X the cost of a 30-day supply. Members who choose not to follow maintenance medication program, will be required to pay 100% of the cost of medications these do not apply to deductible or max out of pocket.

### Required Copay Assistance Program

Many medications come with access to a copay assistance program that can typically lower the cost of the medication to the patient and to the plan. Community Health Direct has a mandatory requirement of a copay assistance program where it applies. There are required steps to enrollment in the required copay assistance program. Failing to follow these steps will result in the members paying much more out of pocket up to the full cost of the medication. Medications that require the use of the copay assistance program are denoted in the Preferred Formulary Medication list as indicated above.

**The members must complete the following steps:**

1. Enroll in a copay assistance program via either of the options below.
    - Option 1: Enroll directly with the drug manufacturer by visiting their website or by calling the copay assistance program for the medication you are taking.

**Prior to filling your next prescription**, contact EpiphanyRx Member Services at 844-547-0399 or email us at memberservices@epiphanyrx.com to let us know you have enrolled in copay assistance.

- Option 2: Call EpiphanyRx member services to assist you with this process by calling EpiphanyRx Member Services at 844-547-0399.

2. If you were enrolled in copay assistance prior to receiving this letter, you will still need to contact EpiphanyRx to confirm your enrollment.
3. Please take your new copay assistance program card with you to the pharmacy to ensure copay assistance is appropriately applied to your cost share or you could end up paying more than you should.

## IV. Medication Prior Authorization (PA) Process

The EpiphanyRx Prior Authorization form is available online here or in the Provider Portal at https://secure.healthx.com/chn.provider and should be faxed to 855-668-8551. EpiphanyRx does require full chart notes from the prescriber's office to review all prior authorization. The turnaround time for PA decisions is 4 business days for non-urgent PAs. A PA request, however, is not considered complete until all requested information is received by EpiphanyRx. If there is a need for a more expedited review due to the patients' clinical factors, a PA may be marked as "URGENT" when submitted and a turnaround time of 24 hours on business days is expected. If a PA is denied, EpiphanyRx will include alternative therapy where indicated/appropriate**.**

### Tips for a Successful Prior Authorization Submission

1. When submitting PA to EpiphanyRx, please provide the following:
    1. Full chart notes
    2. Diagnosis, severity (i.e., mild, moderate, severe) supported with documentation and clinical presentation (i.e., area of the body affected)
    3. All previously tried and currently utilized therapy for diagnosis with dates and duration of trial and failure
    4. If the request is for continuation of therapy detailed, specific information about outcomes must be included (examples: quality of life, historical chart notes, change in symptoms, scoring, imaging and/or lab values)
2. For the specific diagnosis below, we also recommend you include:
    1. Migraine - Number of migraine or headache days per month and description and duration of migraines
    2. Psoriasis/Eczema- BSA

## V. Pharmacy Appeals Process

A provider can request an appeal if they do not agree with a PA denial and/or if the member has a medical necessity for a non-covered medication. The appeals process is handled by EpiphanyRx. A fax for a PA appeal can be sent to 1-855-673-6507. To start a review for non-

covered medication, an exception to cover review can be requested by calling EpiphanyRx on 1-844-547-0399.

## VI. Office Administered Medications

Medication benefits for office supplied and administered medications, sometime referred to as "buy and bill" medications are covered under the medical benefit, not the pharmacy benefit. Claims would be submitted through Community Health Direct Medical Management as opposed to EpiphanyRx. Aduhelm (Aducanumab) is an excluded medication.

The current medications require Prior Authorization and Community Health Direct Medical Management should be contacted for approval.

1. Prolia (denosumab)
2. Entyvio (vedolizumab)
3. Spinraza (nusinersen)
4. Botox when used for hyperhidrosis
5. Any medication used for investigational/experimental usage, e.g., a medication used outside of FDA (Food and Drug Administration) approved indication

## VII. Weight Loss Agents

Currently, prior authorizations for weight loss products are to be directed to Community Health Direct. A weight loss medical Prior Authorization form can be found online here. Members must be enrolled in a healthy lifestyle program; more information can also be found on the previous link. Along with the PA form, clinical notes must be submitted for approval as well as throughout therapy with documented weights.

## VIII. Preferred Pharmacies

### Non-specialty Medications

Walgreens retail locations and AllianceRx Walgreens Pharmacy, as well as select Kroger pharmacies in regions without Walgreens, are the preferred in- network pharmacies. Community EPO members must use Walgreens pharmacies with their benefit plan. In addition, all medications that are part of the required mandatory maintenance program must be filled at a Walgreens pharmacy for a 90-day supply for all Community HDHP and PPO members after the first three (3) 30-day fills.

EpiphanyRx does partner with other pharmacies that would be considered in network for Community HDHP and PPO members for all non-required mandatory maintenance medications. CVS pharmacies are never in network. Medications and other services, such as vaccines, are not covered at CVS pharmacies.

### Specialty Medications

Community Health Network Specialty Pharmacy is the required pharmacy for specialty medications related to oncology and Hepatis C.

Walgreens pharmacies are the preferred pharmacy for all other specialty medications. If a medication is a limited distribution therapy medication, it will then be directed to the correct filling location by either Walgreens or EpiphanyRx.