COMMUNITY FIRST HEALTH PLANS

CHIP | TEXAS Health and Human Services

2024 CHIP PROVIDER MANUAL

COMMUNITY FIRST PROVIDER RELATIONS

PROVIDER SERVICES 210-358-6300

TOLL FREE 1-800-434-2347

CommunityFirstMedicaid.com

Atascosa • Bandera • Bexar • Comal • Guadalupe • Kendall • Medina • Wilson

CFHP_1499GOV_1021

EXHIBITS

Exhibits referred to throughout this Provider Manual can be accessed by clicking the respective links below or by visiting https://medicaid.communityfirsthealthplans.com/resources/providers/.

EXHIBIT	TITLE
Exhibit 1	Request for Continuity/Transition of Care
Exhibit 2	Your Texas Benefits Medicaid Card
Exhibit 3a	Community First CHIP Member ID Card
Exhibit 3b	Community First CHIP Perinate Member ID Card
Exhibit 3c	Community First CHIP Neonate Member ID Card
Exhibit 4	Provider Request for Member Transfer
Exhibit 5	Request for Increase in 1,500 Capacity
Exhibit 6	Texas Standard Prior Authorization Request Form for Health Care Services
Exhibit 7	Tuberculosis Report of Case and Patient Services
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Exhibit 9	Sterilization Consent
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Exhibit 18	Private Pay Agreement
Exhibit 19	Explanation of Payment (EOP) - Sample

EXHIBIT	TITLE
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Exhibit 21	Claim Appeal Submission Form
Exhibit 22	Medicaid Eligibility Verification Form (H 1027-A)
Exhibit 23	Current Immunization Schedule for Pediatrics
Exhibit 24	Blood Lead Screening and Testing Guidelines
Exhibit 25	Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
Exhibit 26	Provider Billing Guidelines
Exhibit 27	Form H3038, Emergency Medical Services Certification

QUICK REFERENCE PHONE LIST

CONTACT	PHONE NUMBER
Member Services Department	1-800-434-2347 (toll-free) (210) 358-6300
Member Services Fax	(210) 358-6099
Eligibility/Benefits Verification	(210) 358-6300
Interpreter Services/Sign Language	(210) 358-6300
Population Health Management	(210) 358-6050
Preauthorization Fax	(210) 358-6040
Urgent Care	(210) 227-2347
Behavioral Health Authorization/Care Management	(210) 358-6100 (Option 3) 1-800-434-2347 (Option 3)
Behavioral Health Fax	(210) 358-6387
NICU Fax	(210) 358-6388
TTY (For the Deaf and Hard of Hearing)	1-800-390-1175
Provider Relations (General Inquiries) Provider Relations (Claims Assistance)	(210) 358-6294 (210) 358-6030
Claims Information	(210) 358-6200
Claims Fax	(210) 358-6199
Electronic Claims	Availity Payor ID: COMMF
Nurse Advice Line (After hour calls are forwarded to Nurse Advice Line)	(210) 358-6300
Preventive Health and Disease Management	1-800-434-2347
Community Outreach Agencies	(210) 358-6159
Pharmacy-Navitus Health Solutions	1-866-333-2757
Vision Inquiries Envolve Benefit Options	 1-800-334-3937
Dental Inquiries DentaQuest MCNA Dental United Healthcare Dental	 1-800-516-0165 1-800-494-6262 1-877-901-7321

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SECTION I

CHIP & CHIP PERINATE NEWBORN PROGRAMS

- Information found in this section (Section I of this Provider Manual) applies to the CHIP and CHIP Perinate Newborn Programs only.
- Please refer to Section II for information applicable to the CHIP Perinate Program only.
- Please refer to Section III for requirements and information applicable to all CHIP programs.

I. CHIP & CHIP PERINATE NEWBORN PROGRAMS

Welcome to the Community First Health Plans Children's Health Insurance Program (CHIP) network.

A. Introduction

1. Background and Objectives of Program

CHIP is a managed care plan for uninsured children in Texas.

The Community First CHIP/CHIP Perinate Newborn network comprises physicians, allied and ancillary health care providers, hospitals, and other facilities selected to provide quality health care to our CHIP Members. The primary care provider (PCP) is responsible for managing the overall medical care of patients and coordinating referrals to specialists and inpatient/outpatient facilities. The PCP is a Community First network provider with one of the following specialties/practice areas:

- General Practice
- Family Practice
- Internal Medicine
- Obstetrics and Gynecology (pregnant women only)
- Pediatrics
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

In addition, Community First Members can access contracted Advance Practice Nurses (APN), Physician Assistants (PA), and Certified Nurse Midwives (CNM), practicing under the supervision of a physician for appropriate covered services.

This Provider Manual is designed to assist you and your staff in working with us to deliver quality health care to Community First CHIP/CHIP Perinate Newborn Members. It provides information regarding our utilization and quality management programs, preauthorization and referral notification procedures, claims filing processes, and our appeals process. We encourage you and your staff to review this Manual carefully and contact your Provider Relations Representative if you have any questions,

comments, or concerns. We welcome suggestions from you and/or your staff for enhancing this Manual.

We will mail updates to your office to advise you of any changes/updates to this Manual. In addition, Community First publishes and distributes a quarterly newsletter to all network physicians and providers. The newsletter includes information such as CHIP/CHIP Perinate Newborn services, policies and procedures, statutes, regulations, and claims processing information. Community First also uses fax alerts, banner messages, special mailings, and our website as additional means to communicate changes/updates to you and your staff.

Following the initial orientation session for Community First CHIP/CHIP Perinate Newborn network physicians and Providers, Community First will have ongoing training sessions when requested by the Provider or deemed necessary by Community First or the Texas Health and Human Services Commission (HHSC). Prior to the effective date of the renewal of our agreement with HHSC, Community First will schedule provider orientations for existing Providers to review program requirements, including changes to covered services, authorization requirements, and claims submission procedures and/or appeal timeframes.

2. Role of the CHIP Member Primary Care Provider (PCP)

PCPs play an integral role in helping meet the objectives of the CHIP program. The program places its main focus on the total well-being of the Member, while providing a "Medical Home" where the Member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. Members are encouraged to become more involved in their own health care and maintain their own wellness. The PCP is responsible for teaching Members how to use available health services appropriately.

PCPs will provide preventive health services in accordance with the program, and related medical policies. They also will coordinate the provision of all covered services to CHIP/CHIP Perinate Newborn Members by:

- Serving as a Medical Home.
- Initiating referrals to network specialty care physicians, network facilities, and allied health care providers.
- Monitoring the Member's progress
- Facilitating the Member's return to the PCP when medically appropriate.

- Educating Members and their families regarding their medical care needs.

Please review the **American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (Exhibit 8)** and **the CDC's Recommended Child and Adolescent Immunization Schedule (Exhibit 23).**

In addition, the PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

The PCP must obtain the Member's consent when seeking services from a Physician Assistant or Nurse Practitioner using the **Supervising Physician Approval Form (Exhibit 15)**.

The PCP will provide, or arrange for the provision of, covered services, and/or telephone consultations during normal office hours, as well as on an emergency basis, 24 hours a day, seven days a week. The PCP is responsible for arranging and coordinating appropriate referrals to other physicians and/or health care providers and specialists and for managing, monitoring, and documenting the services of other providers.

Community First has contracted with an interpreter service for any Provider office that does not have bilingual employees or sign language interpreters. Services are available for sign language, Spanish, English, Vietnamese, and other languages that may be spoken by our CHIP Members. The service is accessible 24 hours a day, seven days a week. Providers can use the service during normal business hours by calling the Member Services Department at **(210) 358-6060** or **1-800-434-2347**. After hours and on weekends, requests for interpreter services are answered by and arranged for through Community First's Nurse Advice Line.

NOTE: The PCP is responsible for contacting Community First to verify Member eligibility and to obtain authorizations for covered services as appropriate.

Members must be educated to seek services from their designated PCP **before** accessing other specialty health care services with the following exceptions:

- Behavioral health services
- Emergency services
- Obstetric/Gynecological services

- Family Planning
- Case Management for Children and Pregnant Women (CPW)
- School Health and Related Services (SHARS)
- Department of State Health Services Case Management (DSHS)
- Mental Health Authorities
- Routine vision services

The PCP is responsible for arranging and coordinating appropriate referrals to other physicians and/or health care providers and specialists and for managing, monitoring, and documenting the services of other providers.

The PCP is responsible for the appropriate coordination and referral of Members for the following services:

- CPW Care Management services
- Early Childhood Interventions (ECI) Care Management services
- Targeted Care Management
- SHARS
- Texas Commission for the Blind Care Management services
- Community First pharmacy benefits through Navitus

Provider Request for Member Transfer

The PCP must submit Community First's **Provider Request for Member Transfer Form (Exhibit 4)**. If you have any questions regarding this process, please contact Community First Provider Relations Department.

PCP CHIP Member Capacity (PCPs only)

If a PCP wishes to limit or expand panel capacity, the PCP must contact Provider Relations. PCPs do not have panel size limitations; however, if increasing capacity to greater than 1,500, a PCP must complete a **Request for Increase in 1,500 Capacity Form (Exhibit 5)** and submit to the Provider Relations Department.

CHIP Member PCP Change

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

3. Role of the CHIP Member Specialty Care Provider

The specialty care provider is responsible for providing medically necessary services to Community First CHIP Members who have been referred by their PCPs for specified treatments and/or diagnostic services. Specialists must verify the eligibility of the referred Member prior to rendering services. If additional visits or services are necessary, the specialist may request authorization to provide these services or arrange for services by contacting Community First's Population Health Management Department. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP's and specialist's medical records.

4. Role of the CHIP Perinate Newborn Primary Care Provider

The PCP is responsible for arranging and coordinating appropriate referrals to other physicians and/or health care providers and specialists and for managing, monitoring, and documenting the services of other providers.

The PCP is responsible for the appropriate coordination and referral of CHIP Perinate Newborns for the following services:

- CPW Care Management services
- Early Childhood Interventions (ECI) Care Management services
- Targeted Care Management
- SHARS
- Texas Commission for the Blind Care Management services
- Community First Pharmacy benefit through Navitus

5. Role of the CHIP Perinate Newborn Specialty Care Provider

The specialty care provider is responsible for providing medically necessary services to Community First CHIP Perinate Newborn Members who have been referred by their PCP for specified treatment or diagnoses. Specialists **should always** verify the eligibility of the referred CHIP Perinate Newborn Member prior to rendering services. Specialists requesting services that require authorization must request the authorization from Community First's Population Health Management Department, prior to rendering services. The specialist must communicate with the PCP regarding services rendered,

results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP's and specialist's medical records.

6. Network Limitations

A CHIP/CHIP Perinate Newborn Member may be assigned to a PCP who is part of a Limited Provider Network (an association of health professionals who work together to provide a full range of health care services). If a Member selects a PCP or is assigned to a PCP in a Limited Provider Network, the PCP will arrange for services through a specific group of specialists, hospitals, and/or ancillary providers who are part of the PCP's network. In such a case, a Member may not be allowed to receive services from any physician or health care professional that is not part of the PCP's network (excluding OB/GYN and behavioral health providers).

7. Providers for Members with Disabilities, Children with Special Health Care Needs (CSHCN), and/or Chronic/Complex Conditions

On an individual case basis, Community First may allow a network specialist currently treating a Member with disabilities or chronic/complex conditions, or who is identified as a CSHCN Member, to serve in the capacity of a PCP for that Member. The network specialist must agree to perform all PCP duties, and such duties must be within the scope of the participating specialist's certification. Network specialists wishing to become PCPs for CHIP Members with disabilities, CSHCN, or chronic/complex conditions must complete the **Request for Continuity/Transition of Care Form** (Exhibit 1) and submit the form to Community First's Population Health Management Department for review. To obtain further assistance in this process, please contact Population Health Management at **(210) 358-6050**.

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

a. Certification by the non-primary care physician specialist as a PCP.
b. A signed statement by the non-primary care physician specialist that they are willing to accept responsibility for the coordination of all the Member's health care needs including referrals to other specialists.

c. The signature of the Member's guardian concurring with the request.

8. Role of Pharmacy and Pharmacy Provider

The pharmacy is responsible for providing pharmaceutical services to Community First CHIP Members. Pharmacy providers must verify the eligibility of the Member prior to rendering services. Pharmacy providers are responsible for:

- Adhering to the Formulary and Preferred Drug List (PDL).
- Coordinating with the prescribing physician.
- Ensuring Members receive all medications for which they are eligible.

9. Role of Main Dental Home

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not choose one. Whether chosen or assigned, each Member who is six (6) months or older must have a designated Main Dental Home.

10. How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of the Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within five (5) business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker toll-free at **1-800-964-2777**.

B. CHIP and CHIP Perinate Newborn Covered Services

CHIP helps children get the services they need to stay healthy, including:

- Dentist visits, cleanings, and fillings
- Eye exams and glasses
- Choice of doctors, regular checkups, and office visits
- Prescription drugs and vaccines
- Access to medical specialists and mental health care
- Hospital care and services
- Medical supplies, X-rays, and lab tests
- Treatment of special health needs
- Treatment of pre-existing conditions

1. CHIP Schedule of Benefits

CHIP COVERED SERVICE	LIMITATIONS
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical	**Requires authorization** for non-emergency care and care following stabilization of an emergency condition. **Requires authorization** for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

CHIP COVERED SERVICE	LIMITATIONS
component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, physician, and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	

CHIP COVERED SERVICE	LIMITATIONS

• Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  o dilation and curettage (D&C) procedures;
  o appropriate provider-administered medications;
  o ultrasounds; and
  o histological examination of tissue samples.
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  o cleft lip and/or palate; or
  o severe traumatic, skeletal and/or congenital craniofacial deviations; or
  o severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
• Surgical implants
• Other artificial aids including surgical implants
• Inpatient services for a mastectomy and breast reconstruction include:
  o all stages of reconstruction on the affected breast;
  o surgery and reconstruction on the other	

CHIP COVERED SERVICE	LIMITATIONS
breast to produce symmetrical appearance; and o treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	
Skilled Nursing Facilities (including Rehabilitation Hospitals) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	**Requires authorization** and physician prescription. 60 days per 12-month period limit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component)	**May require authorization** and physician prescription.

CHIP COVERED SERVICE	LIMITATIONS
• Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: o dilation and curettage (D&C) procedures; o appropriate provider-administered medications; o ultrasounds; and	

CHIP COVERED SERVICE	LIMITATIONS
○ histological examination of tissue samples • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip and/or palate; or ○ severe traumatic, skeletal and/or congenital craniofacial deviations; or ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ○ All stages of reconstruction on the affected breast ○ Surgery and reconstruction on the other breast to produce symmetrical appearance ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards	

CHIP COVERED SERVICE	LIMITATIONS
the DME 12-month period limit	
Physician/Physician Extender Professional Services Services include, but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient, and out-patient services • Laboratory, X-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care o Administration of anesthesia by physician (other than surgeon) or CRNA o Second surgical opinions o Same-day surgery performed in a hospital without an overnight stay o Invasive diagnostic procedures such as endoscopic examinations	**May require authorization** for specialty services.

CHIP COVERED SERVICE	LIMITATIONS

• Hospital-based physician services (including physician-performed technical and interpretive components)
• Physician and professional services for a mastectomy and breast reconstruction include:
  o All stages of reconstruction on the affected breast
  o Surgery and reconstruction on the other breast to produce symmetrical appearance
  o Treatment of physical complications from the mastectomy and treatment of lymphedemas
• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.
• Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation.
• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  o dilation and curettage (D&C) procedures;	

CHIP COVERED SERVICE	LIMITATIONS
○ appropriate provider-administered medications; ○ ultrasounds; and ○ histological examination of tissue samples • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ Cleft lip and/or palate ○ Severe traumatic, skeletal and/or congenital craniofacial deviations ○ Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment	
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily	**May require prior authorization** and physician prescription. $20,000 12-month period limit

CHIP COVERED SERVICE	LIMITATIONS
used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids, including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	for DME, prosthetics, devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN)	**Requires prior authorization** and physician prescription. Services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are

CHIP COVERED SERVICE	LIMITATIONS
• Skilled nursing visits as defined for home health purposes (may include RN, LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical, and occupational therapies	provided on intermittent level and not intended to provide 24-hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing.	**Requires prior authorization** for non-emergency services. Does not require PCP referral. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but are not limited to:	**May require prior authorization**. Does not require PCP referral. When outpatient psychiatric

CHIP COVERED SERVICE	LIMITATIONS
• Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility	services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS

CHIP COVERED SERVICE	LIMITATIONS
	standards. Those services include individual and group skills training (that can be components of, i.e. day treatment and in-home services), patient and family education, and crisis services.
Inpatient Substance Misuse Treatment Services Inpatient substance misuse treatment services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	**Requires prior authorization** for non-emergency services. Does not require PCP referral.
Outpatient Substance Misuse Treatment Services Outpatient substance misuse treatment services include, but are not limited to the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services o Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day	**May require prior authorization**. Does not require PCP referral.

CHIP COVERED SERVICE	LIMITATIONS
○ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Partial hospitalization	
Rehabilitation Services • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: ○ Physical, occupational, and speech therapy ○ Developmental assessment	**Requires prior authorization** and physician prescription.
Hospice Care Services Services include, but are not limited to, the following: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	**Requires authorization** and physician prescription. Services apply to the hospice diagnosis. Up to a maximum of 120 days with a six-month life expectancy. Patients electing hospice services may cancel this election at any time.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	**Requires authorization** for post-stabilization services.

CHIP COVERED SERVICE	LIMITATIONS
Covered services include, but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.
Transplants Services, include but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	**Requires authorization**.
Vision Benefit Services include: • One examination of the eyes to determine the	**Does not require authorization** for protective and polycarbonate lenses when medically necessary as

CHIP COVERED SERVICE	LIMITATIONS
need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	part of a treatment plan for covered diseases of the eye. The health plan may reasonably limit the cost of the frames/lenses.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation.	**Does not require authorization** for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). **Requires authorization** for additional visits.

NOTE: Community First' responsibilities shown above are subject to contractual requirements between Community First and the Provider (i.e.., Authorization List, Claim Submission Requirements) and Member eligibility for CHIP.

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage and Billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage and Billing
			newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the

pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

Emergency Dental Services

Community First is responsible for emergency dental services provided to CHIP Members in a hospital or ambulatory surgical center setting. Community First will pay for hospital, physician, and related medical services (i.e., anesthesia and drugs) for the following:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin

Non-Emergency Dental Services

Community First is **not responsible** for paying for routine dental services provided to CHIP Members. These services are paid through Dental Managed Care Organizations.

Community First **is responsible** for paying for treatment and devices for craniofacial anomalies.

2. CHIP Perinate Newborn Schedule of Benefits

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: • Hospital-provided physician or provider services • Semi-private room and board (or private if	**Requires authorization** for non-emergency care and care following stabilization of an emergency condition. **Requires authorization** for in-network or out-of-network facility and physician services

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following	for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, physician, and related medical services, such as anesthesia, associated with dental care • Surgical implants • Other artificial aids, including surgical implants • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: o cleft lip and/or palate; or o severe traumatic, skeletal and/or congenital craniofacial deviations; or o severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. • Inpatient services for a mastectomy and breast reconstruction include: o all stages of reconstruction on the affected breast; o surgery and reconstruction on the other breast to produce symmetrical appearance; and o treatment of physical complications from the mastectomy and treatment of	

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	
Skilled Nursing Facilities (including Rehabilitation Hospitals) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	**Requires authorization** and physician prescription. 60 days per 12-month period limit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals	**May require authorization** and physician prescription.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS

• Casts, splints, dressings
• Preventive health services
• Physical, occupational, and speech therapy
• Renal dialysis
• Respiratory services
• Radiation and chemotherapy
• Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  ○ cleft lip and/or palate; or
  ○ severe traumatic, skeletal and/or congenital craniofacial deviations; or
  ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment
• Surgical implants
• Other artificial aids including surgical implants	

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS

• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
  o All stages of reconstruction on the affected breast
  o Surgery and reconstruction on the other breast to produce symmetrical appearance
  o Treatment of physical complications from the mastectomy and treatment of lymphedemas
• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit	

Physician/Physician Extender Professional Services Services include, but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient, and out-patient services • Laboratory, X-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medications, biologicals, and materials administered in physician's office	**May require authorization** for specialty services.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS

• Allergy testing, serum, and injections
• Professional component (in/outpatient) of surgical services, including:
  o Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
  o Administration of anesthesia by physician (other than surgeon) or CRNA
  o Second surgical opinions
  o Same-day surgery performed in a hospital without an overnight stay
  o Invasive diagnostic procedures such as endoscopic examinations
• Hospital-based physician services (including physician-performed technical and interpretive components)
• Physician and professional services for a mastectomy and breast reconstruction include:
  o All stages of reconstruction on the affected breast
  o Surgery and reconstruction on the other breast to produce symmetrical appearance
  o Treatment of physical complications from the mastectomy and treatment of lymphedemas
• In-network and out-of-network physician services for a mother and her newborn(s) for a	

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: o Cleft lip and/or palate o Severe traumatic, skeletal and/or congenital craniofacial deviations o Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment	
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers services rendered to a newborn immediately following delivery.
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability,	**May require prior authorization** and physician prescription. $20,000 12-month period limit for DME, prosthetics, devices, and disposable medical

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids, including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	supplies (diabetic supplies and equipment are not counted against this cap).
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health	**Requires prior authorization** and physician prescription. Services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are provided on intermittent level and not intended to provide

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
purposes (may include RN, LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical, and occupational therapies	24-hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing.	**Requires prior authorization** for non-emergency services. Does not require PCP referral. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but are not limited to: • Neuropsychological and psychological testing	**May require prior authorization**. Does not require PCP referral. When outpatient psychiatric services are ordered by a court

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
• Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility	of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
	include individual and group skills training (that can be components of, i.e. day treatment and in-home services), patient and family education, and crisis services.
Inpatient Substance Misuse Treatment Services Inpatient substance misuse treatment services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	**Requires prior authorization** for non-emergency services. Does not require PCP referral.
Outpatient Substance Misuse Treatment Services Outpatient substance misuse treatment services include, but are not limited to the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services o Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day o Outpatient treatment service is defined as	**May require prior authorization**. Does not require PCP referral.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Partial hospitalization	
Rehabilitation Services • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: o Physical, occupational, and speech therapy o Developmental assessment	**Requires prior authorization** and physician prescription.
Hospice Care Services Services include, but are not limited to, the following: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	**Requires authorization** and physician prescription. Services apply to the hospice diagnosis. Up to a maximum of 120 days with a six-month life expectancy. Patients electing hospice services may cancel this election at any time.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Covered services include, but are not limited to, the	**Requires authorization** for post-stabilization services. Health plan cannot require

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	authorization as a condition for payment for emergency conditions or labor and delivery.
Transplants Services, include but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	**Requires authorization**.
Vision Benefit Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses	**Does not require authorization** for protective and polycarbonate lenses when medically necessary as part of a treatment plan for

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	covered diseases of the eye. The health plan may reasonably limit the cost of the frames/lenses.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation.	**Does not require authorization** for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). **Requires authorization** for additional visits.

3. CHIP and CHIP Perinate Exclusions from Covered Services

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (e.g., cannot be prescribed for family planning).
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical, or other health care procedures or services which are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited

to, those for schools, employment, flight clearance, camps, insurance, or court.

- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to, artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by Community First.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by Community First except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by Community First.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy, and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care. (Routine foot care does not include treatment injury or complications of diabetes.)
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails. (This does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails.)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.

- Orthotics primarily used for athletic or recreational purpose.
- Custodial care. (Care that assists a **child** with activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This exclusion does not apply to hospice services.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a physician/PCP.
- Donor non-medical expenses for transplants.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam and American Samoa).

Please Note: The exclusions for CHIP Perinate Newborns match those found in the CHIP Program, with the exception of the following:

- For CHIP Perinate Newborns in families with incomes at or below the Medicaid Eligibility Threshold of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth.

4. Durable Medical Equipment (DME) and Other Products Normally Found in a Pharmacy

NOTE: DME and supplies are a covered benefit for CHIP and CHIP Perinate Newborns, but not CHIP Perinate Members (pregnant women).

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Betadine		X	See "IV Therapy Supplies."
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See "Ostomy Supplies."
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold	X		
Dental Devices	X		
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or

Supplies	Covered	Excluded	Comments/Member Contract Provisions
			ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with

Supplies	Covered	Excluded	Comments/Member Contract Provisions
			amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan). Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For Members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of

Supplies	Covered	Excluded	Comments/Member Contract Provisions
			failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blended and used with an enteral system that are **not** medically necessary, are not covered, regardless of whether these regular food products are taken orally or parentally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets,	X		Eligible for coverage when used

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Wound Care			during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See "Diabetic Supplies."
Needles and Syringes/IV and Central Line			See "IV Therapy and Dressing Supplies/Central Line."
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See "Saline, Normal."
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep,

Supplies	Covered	Excluded	Comments/Member Contract Provisions
			adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Community First has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See "Needles/Syringes"
Tape			See "Dressing Supplies," Ostomy Supplies," "IV Therapy Supplies."
Tracheostomy Supplies	X		Cannulas, tubes, ties, holders, cleaning kits, etc., are eligible for coverage.
Under Pads			See "Diapers/Incontinent

Supplies	Covered	Excluded	Comments/Member Contract Provisions
			Briefs/Chux"
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter, and Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan.
Urinary, Indwelling Catheter, and Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See "Ostomy Supplies"

5. CHIP Pharmacy Program

CHIP Member Prescriptions

Community First covers prescription medications. CHIP and CHIP Perinate Newborn Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

CHIP and CHIP Perinate Newborn Members can get their prescriptions when:

- They get their prescriptions filled at a network pharmacy.
- Their prescriptions are on the preferred drug list (PDL) or formulary.

It is important that you, as the Provider, know about other prescriptions your patient is already taking. Also ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

Preferred Drug List

The Texas Drug Code Index includes the CHIP program-specific formulary. You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs at:

- Texas Drug Non-PA PDL Search
- PDL/PA Status Search

The Texas CHIP preferred drug list is now available on the Epocrates Drug Information System at https://online.epocrates.com/home. The service is free and provides instant access to information on the drugs covered by the Texas formulary.

Formulary Drug List

The Texas Drug Code Formulary covers more than 32,000-line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state's formulary list. Remember, before prescribing these medications to your patient that they may require prior authorization.

If you want to request a drug to be added to the formulary, please contact HHSC at contact@hhsc.state.tx.us. (Subject line: Formulary request)

Over-the-Counter Drugs

Community First also covers certain over-the-counter drugs if they are on the list. Like other drugs, over-the-counter drugs must have a prescription written by the Member's physician. Check the list of covered drugs at Texas Drug Code Formulary.

Network Pharmacy

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Mail Order Forms

Members who use maintenance drugs may fill their prescriptions through mail order. The use of mail order is recommended only for maintenance drugs, rather than drugs that will be needed for a short time (e.g. antibiotics for an acute illness). Maintenance drugs are typically used to treat chronic, long-term conditions.

The following VDP registered pharmacy accommodates mail order prescriptions for CHIP Members:

H-E-B
NPI 1801185004
8300 Floyd Curl Drive
San Antonio, TX 78229

Phone: **210-593-0291**

You can assist your Member in completing the mail order process if you are prescribing a maintenance medication.

General Guidelines

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The Preferred Drug List (PDL) gives information about the drugs covered by Community First. For the most current and up-to-date version of the PDL, visit CommunityFirstMedicaid.com.

CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of certain maintenance medications. Not all medications may be filled for a 90-day supply.

Brand-Name Medications

Brand-name medications that are listed on the PDL are designated in all CAPS and are covered by the plan. The PDL may cover the brand and generic versions of certain medications.

Pharmacy Prior Authorization (PA)

Pharmacy prior authorization may be required if:

- Prescriptions exceed recommended doses.
- Highly specialized drugs are prescribed which require certain established clinical guidelines be met before consideration for prior approval.
- Quantity limits are exceeded.

Procedure for Obtaining Pharmacy Prior Authorization

Navitus Health Solutions is the pharmacy benefit manager for Community First. Navitus processes CHIP pharmacy prior authorizations.

The Texas Vendor Drug Program (VDP) retains accountability for making formulary decisions which includes establishing quantity limits and prior authorization criteria.

Prescribers can access prior authorization (PA) forms online via www.navitus.com under the "Prescribers" section or have them faxed by Navitus Customer Care to the prescriber's office. Prescribers will need their NPI and state to access the portal.

Completed forms can be faxed 24 hours a day, 7 days a week to Navitus at **1-855-668-8553**. Prescribers can also call Navitus Customer Care at **1-877-908-6023** to speak with the Prior Authorization Department between 8:00 a.m. and 5:00 p.m., Monday through Friday (CST) to submit a PA request over the phone. After hours, Providers will have the option to leave a voicemail. Decisions regarding PAs will be made within 24 hours from the time Navitus receives the PA request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require PA will undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispending process. If the automated review determines that all the criteria are not met, the claim will be rejected, and the pharmacy will receive a message indicating that the drug

requires PA. At that point, the pharmacy should notify the prescriber and the above process should be followed.

When a PA is required and the Provider is not available to submit the PA request, HHSC encourages pharmacies to dispense a 72-hour supply as long as the Member will not be harmed. This procedure should not be used for routine and continuous overrides but can be used more than once if the Provider remains unavailable. If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of the Inspector General and Navitus' Network Department at **(608) 729-1577** for review.

6. CHIP and CHIP Perinate Newborn Extra Benefits (Value-Added Services)

CHIP and CHIP Perinate Newborn Members receive the following extra benefits or "Value-Added Services" with Community First. If you have any questions about our Value-Added Services, please call **(210) 358-6060**.

NOTE: There is no spell-of-illness limitation for CHIP Members and CHIP Perinate Newborn Members.

CHIP/CHIP Perinate Newborn Value-Added Services	Limits and Restrictions
$10 gift card for completing the Community First General Health Assessment	Limited to new members; one per household.
Toddler booster seat for children current with their CHIP well-child checkup	For ages 4-10.
Baby car seat or safe sleep play yard	Offered to CHIP Members until they are placed in Medicaid or for Members who are not Medicaid eligible. Limited to pregnant Members. Upon completion of Healthy Expectations Maternity Program Mommy & Me Baby Shower.
Up to $25 in gift cards for completion of Adolescent	For ages 9-13. Gift card restrictions include no beer, wine, alcohol, cigarettes and OTC drugs

CHIP/CHIP Perinate Newborn Value-Added Services	Limits and Restrictions
Immunizations	may be purchased.
Enhanced vision benefits with up to $125 for frames or $75 for contact lenses	Available every year for Members ages 21 and up; every other year for Members 22 and up. Limited to either contact lenses or glasses, not both. Replacement of eyewear due to loss or breakage is available as allowed by benefit program. Otherwise, replacement is available when there is a change in vision.
No-cost sports/school physicals	One physical each year for Members ages 18 and younger.
24-Hour Nurse Advice Line	None
Up to $120 in gift cards for pregnant Members who enroll in Healthy Expectations Maternity Program and complete prenatal services	Offered to CHIP members until they are placed in Medicaid or for members who are not Medicaid eligible. Limited to pregnant Members. Upon Member's enrollment in Healthy Expectations Maternity Program and agreement to receive Healthy Baby texts ($20); Healthy Expectations baby shower attendance ($10); attendance of first prenatal visit in first trimester or within 42 days of enrolling in the health plan ($20); receipt of the flu shot ($20); attendance of postpartum visit 7-84 days after delivery ($20). Member may be eligible to receive an additional $30 gift card reimbursement upon attendance of a birthing class or towards pregnancy pillow. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.
Low-cost dental services	For Members ages 21 and up and their family members without dental coverage.
Healthy Expectations Maternity Program	Limited to pregnant Members. Offered to CHIP Members until they are placed in Medicaid or for

CHIP/CHIP Perinate Newborn Value-Added Services	Limits and Restrictions
	Members who are not Medicaid eligible.
Mommy & Me Baby Shower	Limited to one baby shower per pregnancy, one diaper bag, and one gift card per Member. Baby shower must be hosted during Member's pregnancy. Limitation does not include mothers expecting multiples. Free gifts for fathers who attend baby shower with mom. Gift card restrictions include no beer, wine, alcohol, cigarettes, or OTC drugs may be purchased.
Zumba classes with free fitness giveaways	Giveaways upon Member's attendance of three Zumba classes or reaching a weight goal.
No-cost smoking cessation resources	None
Gift program and assistance for Members with asthma	One peak flow meter and aerosol holding chamber each year for Members with asthma; one allergy-free protector pillowcase each year for Members with asthma; $10 gift card upon completion of asthma education session. Members must be enrolled in Asthma Matters: Asthma Management Program. Gift card restrictions include no beer, wine, alcohol, cigarettes, or OTC drugs may be purchased.
Transportation assistance to Community First hosted events, health education classes, and to attend Member Advisory Group meetings	Children under the age of 18 must be accompanied by a parent or guardian. Assistance available only when the state Medical Transportation Program is not available. The service is available only for established bus service routes, which are exclusive to San Antonio and routes are predetermined by VIA Metropolitan Transit.
YMCA Diabetes Prevention Program, including a 4-month	YMCA membership available after attending the fifth program session. For members 13 years and

CHIP/CHIP Perinate Newborn Value-Added Services	Limits and Restrictions
YMCA membership for two adults and up to four children	older (unless otherwise indicated in the program) with a signed release by the Member.
Y Weight Loss Program-16 Weeks to Wellness, including a 4-month YMCA membership for two adults and up to four children	YMCA membership available after attending the third program session. For members 13 years and older (unless otherwise indicated in the program) with a signed release by the Member.
YMCA Blood Pressure Self-Monitoring Program, including a free blood pressure cuff	Blood pressure cuff available while supplies last. For members 13 years and older (unless otherwise indicated in the program) with a signed release by the Member.
Gift program and assistance for Members with diabetes	Up to $50 in gift cards for members enrolled in Diabetes in Control: Diabetes Management Program. $20 gift card for enrolling in the program; $10 gift card for participation in the educational sessions; $10 gift card for receiving a dilated eye exam; $10 gift card for receiving an A1c screening. Gift card restrictions include no beer, wine, alcohol, cigarettes, or OTC drugs may be purchased.
Behavioral health inpatient follow-up incentive program	$25 gift card for attending follow-up appointment after leaving a behavioral health hospital. Must attend appointment within seven days of discharge. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.
Online mental health resources	None
Bike safety and repair classes with free giveaway	Upon completion of the bike safety class, Members and their families will receive a free giveaway.

CHIP/CHIP Perinate Newborn Value-Added Services	Limits and Restrictions
Prescription Savings Card approved for use by uninsured family members	None
Smart phone with up to 500 minutes including unlimited texting and 4.5 GB of data	Limited to one per household.
No-cost notary services for Members' medical documents	Members must have a valid state issued identification card or driver's license.

C. Coordination with Non-CHIP/CHIP Perinate Newborn Covered Services (Non-Capitated Services)

1. Texas Agency Administered Programs and Case Management Services

Community First coordinates, through its contractual relationship with Texas Agency Administered Programs and Essential Public Health Services, regarding the provision of services for essential public health services for CHIP/CHIP Perinate Members to include:

- Children with Special Health Care Needs (CSHCN) Program
- Pharmacy Benefit through Navitus
- CHIP Dental Program
- Mental Health Targeted Case Management
- Mental Health Rehabilitation
- Texas Commission for the Blind Case Management
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)

2. Essential Public Health Services

Community First works with the Health and Human Services Commission (HHSC) through a Memorandum of Understanding (MOU) to provide essential public health

services. Community First makes a good faith effort to enter into a subcontract for covered services with Essential Public Health Entities in support of its mission to diagnosis and investigate diseases, health problems and threats to the public's health. covered services that could be provided by Public Health Entities include, but are not limited to, the following services:

- Sexually Transmitted Diseases (STDs) services
- Confidential HIV testing
- Immunizations
- Tuberculosis (TB) care
- Family Planning services
- Prenatal services

The PCP is responsible for the appropriate coordination and referral of Members for these services.

Dental Services

Dental services for CHIP Members are covered from birth through the age of 18 years. Children should have their first dental checkup at 6 months of age and every 6 months thereafter. Services include all medically necessary dental treatment (e.g., exams, cleanings, X-rays, fluoride treatment, and restorative treatment), including orthodontia. Children under the age of 6 months can receive dental services on an emergency basis. For more information, Members may contact their Dental Managed Care Organization:

- DentaQuest: **1-800-516-0165**
- MCNA Dental: **1-800-494-6262**
- United Healthcare Dental: **1-877-901-7321**

Community First is not responsible for the payment of dental services.

Mental Health Targeted Case Management

Community First, working with the Member's PCP through the Local Mental Health, will assess the Member's eligibility for rehabilitative and targeted DSHS case management. The Texas CHIP Program provides the following service coordination and case management services:

- Service coordination for people with mental retardation or related condition (adult or child) per consumer, per month.

- Cars management for people with serious emotional disturbance (children ages 3 through 17).
- Individual community support services service coordination for people with mental retardation or related condition (adult or child).

A Mental Health and Mental Retardation (MHMR) service coordination reimbursable contact is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual eligible for service coordination. To bill and be paid for one unit of service coordination per month, at least one face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

A MHMR case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Individual Community Support Services

Service	Proc Code	Modifier	Limitation
Service Coordination for People with Mental Retardation or Related Condition (Adult or Child)	G9012		Once per calendar month
Routine Case Management (Adult)	T1017	TF	32 units (8 hours) per calendar day for people 18 years of age or older
Routine Case Management (Child & Adolescent)	T1017	TF and HA	32 units (8 hours) per calendar day for people less than 18 years of age
Intensive Case Management (Child & Adolescent)	T1017	TG and HA	32 units (8 hours) per calendar day for people less than 18 years of age.

Mental Health Rehabilitation

Service	Proc Code	Modifier	Limitations

Service	Proc Code	Modifier	Limitations
Day Program for Acute Needs	G0177		6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Day Program for Acute Needs, ACT, or ACT Alternative Consumer	G0177	HK	6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Rehabilitative Counseling and Psychotherapy, Individual	H0004		A minimum of 3 units (45 continuous minutes) to a maximum of 16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Rehabilitative Counseling and Psychotherapy, Group	H0004	HQ	A minimum of 3 units (45 continuous minutes) to a maximum of 16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Medication Training and Support, Adult Individual	H0034		8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Adult, ACT or ACT Alternative Consumer, Individual	H0034	HK	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Adult, Group	H0034	HQ	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Adult, ACT or ACT Alternative Consumer, Group	H0034	HK and HQ	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Child & Adolescent, Individual	H0034	HA	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Medication Training and Support, Child & Adolescent, with Other, Individual	H0034	HA and HQ	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age

Service	Proc Code	Modifier	Limitations
Medication Training and Support, Child & Adolescent, with Other, Group	H0034	HA, HQ, HR or UK	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Crisis Intervention Services, Adult	H2011		96 units (24 hours) per calendar day, in any combination
Crisis Intervention Services, Adult, ACT or ACT Alternative Consumer	H2011	HK	96 units (24 hours) per calendar day, in any combination
Crisis Intervention Services, Child & Adolescent	H2011	HA	96 units (24 hours) per calendar day, in any combination
Skills Training and Development, Adult, Individual	H2014		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Adult, Group	H2014	HQ	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Child & Adolescent, Individual	H2014	HA	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Child & Adolescent, with Other, Individual	H2014	HA and HR or UK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, Individual	H2017		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT Alternative Consumer, Individual	H2017	HK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, by RN, Individual	H2017	TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial	H2017	HK and	16 units (4 hours) per calendar day, in

Service	Proc Code	Modifier	Limitations
Rehabilitative Services ACT or ACT Alternative Consumer, by RN, Individual		TD	any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, Group	H2017	HQ	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT Alternative Consumer, Group	H2017	HQ and HK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, by RN, Group	H2017	HQ and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT Alternative Consumer, by RN, Group	H2017	HQ and HK and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, Individual, Crisis	H2017	ET	96 units (24 hours) per calendar day, in any combination
Psychosocial Rehabilitative Services, ACT or ACT Alternative Consumer, Individual, Crisis	H2017	HK and ET	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older

Texas Commission for the Blind Case Management

Service Description: A rehabilitation agency that assists persons with a visual impairment with finding and maintaining a job. They offer case management, counseling, referrals, physical and mental restoration, visual aids, and mobility programs.

Phone: **1-877-787-8999**
Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday

Eligibility: Persons with visual impairments
Fee Structure Details: None

Resource Categories:

- Employment and Financial Assistance
- Mobility and Transportation
- Communication
- Assistive Technology
- Psychological and Counseling Services
- Post-Secondary Education Services

The Division for Blind Services Blind Children's Vocational Discovery and Development Program (BCVDDP)

BCVDDP helps Texas families by providing information and support to help their children grow and thrive. A Blind Children's Program Specialist – an expert in providing services to children with visual impairments – works with each child and family to create a Family Service Plan. The plan, tailored to the child's unique needs and circumstances, is a flexible document that will develop along with the child.

Who is eligible? Children between the ages of birth and 22 years who live in Texas and have vision impairment are eligible for services.

What services are available? BCVDDP offers a wide range of services that are tailored to each child and family's needs and circumstances. Services include:

- Assistance for child to develop the confidence and competence needed to be an active part of their community.
- Support and training to parents in understanding their rights and responsibilities throughout the educational process.
- Assistance for parents and child in the vocational discovery and development process.
- Training in areas like food preparation, money management, recreational activities and grooming.
- Information to families about additional resources.

By working directly with the entire family, this program can help the child develop the concepts and skills needed to realize their full potential.

Where can Members apply for services or get more information? For information on any Division for Blind and Visually Impaired Services program or to apply for services, Members can call the Office of the Ombudsman at **1-877-787-8999**, select a language, and then select Option 3. Members can also submit a request online.

Tuberculosis (TB) Services Provided by DSHS-Approved Providers

Community First Providers must report all confirmed or suspected cases of TB for a contact investigation and directly observed therapy (DOT) to Local Tuberculosis Control Health Authority (LTCHA) within one (1) working day of identification, using the procedures and forms for reporting TB adopted by DSHS (**Exhibit 7**).

Community First Providers must coordinate with LTCHA and report any Community First CHIP Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

Communicable/Infectious Diseases

Community First Providers must report all conditions on the Infectious Disease Report as indicated as when to report each condition. **Suspected cases of illness considered to be public health emergencies, outbreaks, exotic diseases, and unusual group expressions of disease must be reported to the local health department or DSHS immediately.** Other diseases for which there must be a quick public health response must be reported **within one (1) working day.** All other conditions must be reported to the local health department or DSHS **within one (1) week.**

Community First Providers must report notifiable conditions, or other illnesses that may be of public health significance, directly to the **local or health service regions** by using Infectious Disease Report. Paper reporting forms can be obtained by calling your local or health service region. As a last resort or in case of emergency, reports can be made by telephone to the state office at **1-800-252-8239** or **512-458-7111**. Calling **512-458-7111** after hours will reach the physician/epidemiologist on call.

Lead Screening Program

Community First Providers must follow the **Blood Lead Screening and Testing Guidelines for Texas Children** (**Exhibit 24**). Community First Providers must report all cases with an elevated blood level of 10 mcg/dL or greater to:

Texas Childhood Lead Poisoning Prevention Program
Epidemiology & Disease Surveillance Unit
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Phone: **1-800-588-1248**
Website: www.dshs.state.tx.us/lead

Women, Infants and Children Program (WIC)

WIC is a nutrition program that helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy. Nutrition education and counseling, nutritious foods, and help accessing health care are provided to low-income women, infants, and children through the Special Supplemental Nutrition Program, popularly known as WIC.

Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. Please visit https://texaswic.org/ for more information.

WIC Eligibility Requirements

- **Meet the income guidelines.** Households with incomes at or below the Medicaid Eligibility Threshold of the Federal Poverty Level are eligible according to the Texas WIC Income Guidelines. WIC determines income based on gross income. WIC counts all of the Members of a household, related, or unrelated. WIC counts an unborn baby as a household member.

- **Be at nutritional risk.** WIC clients receive an initial health and diet screening at a WIC clinic to determine nutritional risk. WIC uses two main categories of nutritional risk: (1) medically based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and (2) diet-based risks such as poor eating habits that can lead to poor nutritional and health status. Clients will be counseled at WIC about these risks and the outcome influenced by nutrition education and nutritious foods provided by WIC.

- **Live in Texas.** WIC clients usually receive services in the county where they live. U.S. citizenship is not a requirement for eligibility.

- Clients must apply **in person** except in certain limited cases.

All WIC services are free to those who are eligible.

WIC provides benefits each month which are taken to grocery stores and used to buy nutritious foods. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C–rich fruit and vegetable juice, milk, eggs, cheese, beans, and peanut butter. Different food packages are issued to different clients. For example, mothers who are totally breastfeeding their babies without formula are issued tuna and carrots in addition to other foods.

Clients also receive encouragement and instruction in breastfeeding. In many cases, breastfeeding women are provided breast pumps free of charge. WIC helps clients learn why breastfeeding is best for their baby and how to breastfeed while still working.

For information on how to apply for WIC, call **1-800-942-3678**.

Hospice Services

HHSC manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services unrelated to the treatment of the client's terminal illness and for certain physician services (not the treatments).

CHIP Hospice provides palliative care to all CHIP-eligible Members (no age restriction) who sign statements electing hospice services and are certified by physicians to have six (6) months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

When Members elect hospice services, they waive their rights to all other CHIP services related to their terminal illness. They do not waive their rights to CHIP services unrelated to their terminal illness. Medicare and CHIP Members must elect both the Medicare and CHIP Hospice programs. Individuals who elect hospice care are issued a

Texas Benefits CHIP Card with "hospice" printed on it. Members may cancel their election at any time.

HHSC pays the Provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

For HHSC hospice billing questions, call **(512) 490-4666**.

When the services are unrelated to the terminal illness, CHIP (TMHP) pays its providers directly. For questions about hospice billing, call TMHP at **1-800-626-4117**. Providers are required to follow CHIP guidelines for prior authorization when filing claims to TMHP for hospice clients. Fax authorization requests to **(512) 514-4209**.

Non-hospice providers may be reimbursed directly by TMHP for services rendered to a CHIP hospice client.

Mail paper claims to the following address:

Texas CHIP & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

You can request a formal appeal by filing a written request for a hearing so that HHSC receives it within 15 days after you receive HHSC's official notice of action. The request must be addressed to:

Fairy Rutland, Hearings Department
Health and Human Services Commission
P.O. Box 149030
Mail Code W-613
Austin, TX 78714-9030

The request for the hearing may be in the form of a petition or letter. It must state the reason for appeal. You must be notified in writing at least 20 days before the date of the

formal appeal hearing, or, if the hearing is expedited, 10 days before the formal appeal hearing. You may submit written notification to HHSC of withdrawal of the hearing request any time before conclusion of the formal appeal hearing.

Texas Vaccines for Children Program

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled providers for administration to individuals birth through 18 years of age.

Qualified CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form located on the DSHS TVFC website at www.dshs.state.tx.us/immunize/TVFC/default.shtm.

Community First will pay for TVFC Program provider's private stock of vaccines, but only when the TVFC posts a message on its website that no stock is available. In that case, Providers should submit claims for vaccines with the "U1" modifier, which indicates private stock. Providers should only submit claims for private stock until the vaccine is available from TVFC again. Community First will no longer reimburse Providers for private stock when the TVFC stock is replenished.

3. Family Planning Services

Family Planning Services Definition

Family planning services are preventive health, medical, counseling, and educational services, which help individuals in managing their fertility and achieving optimal reproductive and general health.

If a Member requests contraceptive services or family planning services, the Provider must also provide the Member counseling and education about family planning and available family planning services.

Providers cannot require parental consent for Members who are minors to receive family planning services. Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

Rules and Regulations

The Social Security Act governing TANF mandates offering and promptly providing family planning services to prevent and reduce unplanned and out-of-wedlock births for appropriate adults and youths, including minors who may be considered sexually active.

- Family planning Members must have freedom of choice in the selection of contraceptive methods, as medically appropriate.

- Family planning Members must have the freedom to accept or reject services without coercion.

- Family planning services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, disability, religion, national origin, or contraceptive preferences.

- Only the CHIP Member, not their parents, spouses, or any other individual, may consent to the provision of family planning services. However, counseling may be offered to adolescents, which encourages them to discuss family planning needs with a parent, an adult family Member, or another trusted adult.

- Federal regulations require the safeguarding of a CHIP Member's confidential choice of birth control and family planning services. Seeking information from third party insurance resources may jeopardize the CHIP Member's confidentiality; therefore, prior insurance billing is not a requirement for billing family planning.

Access to Family Planning Services

CHIP Members may select any Texas CHIP Provider to perform their family planning services. The Provider's participation with Community First is not mandatory.

Family Planning Visits

A family planning annual visit is allowed once per year (per State's fiscal year: September 1 through August 31), per Provider. If a Provider inadvertently bills a second annual exam, the procedure code will be automatically changed to 99213**,** and reimbursed at the lesser of the current CHIP fee schedule or the contracted rate.

Specific Family Planning Procedure Codes and Definitions

To be reimbursed for an annual visit, the Provider must perform a comprehensive health history and physical examination, provide indicated laboratory evaluations, assess the CHIP Member's problems and needs, and set up an appropriate management plan.

The history and physical examination must include the following:

Female Members

Health History

- Gynecologic history including sexual history and STD/HIV risk
- Menstrual history
- Contraceptive history
- Obstetric history
- Medical and surgical history
- Family/genetic history
- Social history, to include tobacco, substance abuse, alcohol, and domestic violence

Physical Examination

- Height (annually for Members until they are five years post-menarchal)
- Weight
- Blood pressure
- Head, neck (including thyroid)
- Lymph nodes
- Heart
- Lungs
- Breasts (including instruction in self-examination, reinforcement annually)
- Abdomen
- Back
- Extremities
- Pelvic examination
- Rectal examination, as indicated

Male Members

The history and physical examination must include the same general elements as females but should be specific for males.

Family Planning Office or Member Visit (Follow-Up)

A follow-up visit is allowed for routine contraceptive surveillance, family planning counseling/education, contraceptive problems, and suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem (related to a family planning annual visit) or follow-up visit the following must occur:

- An update of Member's history.
- Physical exam, if appropriate.
- Laboratory tests, if appropriate.
- Referral to PCP, if appropriate.
- Education/counseling, if appropriate.

After a contraceptive method is initially provided, the first routine follow-up visit must be scheduled in accordance with the following, unless specifically indicated otherwise:

- Between three and four months for oral contraceptive users (visit must include blood pressure and weight).
- One week and three to four months for implantable Contraceptive Capsules users, according to protocols (visits must include blood pressure and weight).
- After the next normal menses, or no more than six weeks after they insert an IUD.
- Two and one-half to three months for Depo Provera users.

1-99429 Initial Member Education

This visit is to assist in the effective selection of a contraceptive method and will only be reimbursed once for a new CHIP Member, per Provider. The Provider may repeat the visit no more than once per state fiscal year, per Provider. An initial CHIP Member Education visit may be billed in conjunction with an annual or follow-up visit.

The visit must be performed as follows:

- Every new CHIP Member requesting contraceptive services or family planning must be provided with CHIP Member education verbally, in writing, or by audiovisual materials.
- Over-the-counter contraceptive methods may be provided before the CHIP Member receives education but must be accompanied by written instructions for correct use.

The Provider may alter the following initial CHIP Member education, according to the educator's evaluation of the CHIP Member's current knowledge:

- General benefits of family planning services and contraception.
- Information on male and female basic reproductive anatomy and physiology.
- Information regarding particular benefits, potential side effects, and complications of all available contraceptive method.
- Information concerning all the Member's available services, the purpose and sequence of procedures, and a routine schedule of return visits.
- Breast self-examination rationale and instructions, unless provided during the physical exam (for females).
- Information on HIV/STD infection, prevention, and safe sex discussion.

1-99401 - Method-Specific Education/Counseling

This visit should give the CHIP Member information about the contraceptive chosen by the CHIP Member, and include proper use, possible side effects, complications, reliability, and reversibility. The Provider should provide these services when initiating a method, changing contraceptive methods, or the CHIP Member is having difficulty with their current method. This visit can occur along with an annual or follow-up visit. The number of occurrences for this visit will be determined by the number of contraceptive methods chosen by the CHIP Member.

Education counseling must include the following:

- Verbal and written instructions for correct use and self-monitoring of the method chosen.
- Information regarding the method's mode of action, safety, benefits and Effectiveness.
- Backup method review when appropriate and instructions on correct use.
- Demonstration of appropriate insertion and removal of a diaphragm or cap at the time of fitting.

1-99402 Problem Counseling

This visit deals with situations that do not relate to a contraceptive method. Examples include pregnancy, sexually transmitted diseases, social and marital problems, health disorders, sexuality concerns, and preconception counseling (for an identified problem that could jeopardize the outcome of a pregnancy). This visit may be billed along with an annual or follow up visit. CHIP Members who become pregnant (assessment reveals potential pregnancy) must be provided preconception counseling regarding the modification and reduction of that risk.

If a CHIP Member requests information about options for an unintended pregnancy or nondirective counseling, then an appropriate referral must be provided for the following:

- Prenatal care and delivery.
- Infant care, foster care, or adoption.
- Pregnancy termination (not required of natural family planning agencies).

1-S9445 Introduction to Family Planning in Hospital Setting/Auspices

This visit provides an overview of family planning services available to the CHIP Member and encourages pregnant or postpartum women to use such services following their delivery.

1-H1010 Instruction in Natural Family Planning Methods (per session)

This visit is for either a couple or individual and may consist of two sessions. When the Provider is billing for these services, they must indicate a quantity of two in block 24G of the CMS-1500, or next to the description in field locator 46 on the UB-04, when billing two sessions together.

Annual Family Planning Exam and Office Visit

Procedure Code	Description
1-99203	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: a detailed history; a detailed examination; a medical decision making of low complexity, counseling and/or coordination of care with other providers or agencies are provided.
-or-	
1-99214	Office or other outpatient visit for the E&M of an established patient, which requires at least two of these three components: a detailed history, a detailed examination; a medical decision making of moderate complexity, counseling and/or coordination of care.
-with-	
Modifier FP	Service provided as part of CHIP Family Planning Program or FP diagnosis.
1-99213	Office or other outpatient visit.

Family Planning Diagnosis and Procedure Codes

Diagnosis Codes

Several diagnosis codes are acceptable for billing family planning services, however, to simplify the process, Providers are encouraged to use a single diagnosis with all family planning procedures and services. The recommended diagnosis code is "V25.09 - Encounter for contraceptive management, other."

The following procedure codes are authorized for use when billing family planning services:

Family Planning Visits

1-99213

Laboratory in Provider's Office

TITLE V and XX

5-80061 5-81002 5-81015 5-81025 5-81099

5-82465	5-82947	5-83020	5-84478	5-85013
5-85018	5-85025	5-85660	5-86580	5-86592
5-86701	5-86762	5-87070	5-87205	5-87797
5-88150	5-88230	5-88262		

TITLE XIX

5-80061	5-81000	5-81002	5-81015	5-81025
5-81099	5-82465	5-82947	5-83020	5-83718
5-83719	5-83721	5-84478	5-84702	5-84703
5-85013	5-85014	5-85018	5-85025	5-85660
5-86317	5-86403	5-86580	5-86592	5-86689
5-86701	5-86702	5-86703	5-86762	5-86781
5-86850	5-86900	5-86901	5-87070	5-87076
5-87077	5-87086	5-87088	5-87110	5-87205
5-87797	5-88142	5-88150	5-88230	5-88262

5-99000 with modifier FP

NOTE: Only the office that performs the laboratory procedure(s) may bill for the laboratory procedure(s). Providers may be reimbursed one lab handling fee per day, per CHIP Member, unless the Provider obtains multiple specimens and sends them to different laboratories. Lab handling fees will be paid for specimens obtained by venipuncture or catheterization only.

All Providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). If Providers do not comply with CLIA, Community First will not reimburse them for laboratory services.

Laboratory Outside Provider's Office

When it is necessary to send a CHIP Member out of the Provider's office for laboratory services, the Provider must direct the CHIP Member to a laboratory identified as a Community First Provider.

Radiology in Provider's Office

4-74000
4-74010
4-76815

NOTE: Only the office that performs the radiology procedure(s) may bill for the radiology procedure(s).

Radiology Outside Provider's Office

When it is necessary to send a CHIP Member out of the Provider's office for radiology services, the Provider must direct the Member to a radiology facility identified as a Community First Provider.

Contraceptive Devices and Related Procedures

9-A4261	9-A4266	1-J7300	1-J7302	2-11976
2-57170	2-58300	2-58301		

Drugs and Supplies

9-A4261	9-A4266	1-A4267	1-A4268	1-A4269
1-A9150 with modifier FP		1-J1055	1-J1056	1-J3490
1-S4993				

Medical Education/Counseling

1-H1010
1-S9445 with modifier FP
1-S9470*
1-99401 with modifier FP
1-99402 with modifier FP
1-99411***
1-99429 with modifier FP

*Title V only
**Title XX only

Sterilization Services (Global Fees)

Complete: 1-55250* 1-58600*
*Global fee

Title V and Title XX Only

For incomplete procedures, one of the following diagnoses must be present on the claim in addition to the diagnosis for sterilization:

V641	V642	V643

Tubal Ligation: 58600
Vasectomy: 55250

NOTE: A **Sterilization Consent Form** and instructions is identified as (**Exhibit 9**) in this Manual. Prior to performing any sterilization procedures, this consent form must be completed in accordance with its instructions.

Medical Conditions

If the family planning provider is not the CHIP Member's PCP and the CHIP Member presents with a "medical condition," the family planning provider must refer the CHIP Member to their PCP for the appropriate treatment and/or referral for specialty services.

4. Access to Telemedicine, Telemonitoring, and Telehealth

CHIP Members have access to Providers who offer telemedicine, telemonitoring, and telehealth services. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code § 531.0217.

Access to School-Based Telemedicine Services

As required by Texas Government Code § 531.0217, school-based telemedicine medical services are a covered service for Members. Community First will reimburse the distant site physician providing treatment even if the physician is not the patient's primary care provider or provider or is an out-of-network physician. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code § 531.0217 (c-4).

Community First does not require prior authorization for school-based telemedicine medical services.

D. Behavioral Health

1. Behavioral Health Definitions

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

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

An **urgent behavioral health situation** is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the Member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

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

Severe and Persistent Mental Illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by the following:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or

- Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

Severe Emotional Disturbance (SED) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking, and feeling.

2. Behavioral Health Covered Services

- Behavioral health screening.
- Inpatient mental health and substance abuse hospitalization (free standing hospital and general acute-care hospital and Department of State Health Services licensed facilities).
- Treatment by psychiatrists, psychologists, LPCs, LCSW-ACPs, LMFTs, and LCDCs.
- Outpatient behavioral health counseling services are available for all CHIP Members.
- Authorized inpatient hospital services, including services provided in freestanding psychiatric facilities.

3. PCP Requirements for Behavioral Health

PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his or her practice.

PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Assessment Instruments for Behavioral Health Available for PCP Use

Community First requires, through provisions in its Professional Provider Agreement, that a Member's PCP have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their training and practice.

For network PCPs, Community First will provide or arrange for training on how to screen and identify behavioral health disorders and the Community First referral process for behavioral health services and clinical coordination

requirements for such services. Community First will also provide general assessment tools for PCPs as they are developed.

4. Behavioral Health Services

Member Access to Behavioral Health Services

A CHIP Member can access behavioral health services through:

- Self-referral to any network behavioral health provider.
- Contacting Community First at **(210) 358-6100** or **1-800-434-2347** to obtain a list of network behavioral health providers.

Community First does not require a PCP referral for CHIP Members to schedule an initial consultation with a network behavioral health provider.

A Community First Registered Nurse is also available to receive calls 7 days a week, 24 hours a day, including holidays, to provide the following services:

- An initial/concurrent review of Members admitted to the hospital or receiving services to determine coverage.
- Assist with obtaining information and checking eligibility.
- Preauthorization determinations as requested.

Consultation regarding the appropriateness of the level of care is available through Community First's Care Management staff.

Psychological/Neuropsychological testing requires preauthorization by faxing the **Psychological Testing Request Form (Exhibit 10)** to **(210) 358-6387**.

Attention Deficit Hyperactivity Disorder

ADHD is covered on an outpatient basis by a psychiatrist or PCP if medication is required. ADHD is treated in individual and family therapies. It is preferred that both services (medication and therapy) be used for this condition.

Community First's current authorization list indicates that the first 20 outpatient visits do not require preauthorization with a participating Provider.

- Outpatient visits beyond the first 20 visits requires preauthorization.
- Authorization of ADHD services is not a guarantee of payment.

Substance Use Disorder (SUD)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to **Substance Use Disorders**, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Coordination Between Behavioral Health and Physical Health Services

Community First requires, through provisions of its Professional Provider Agreement, that the PCP will screen and evaluate for the detection and treatment and referral of any known or suspected behavioral health problems and disorders. The PCP will provide any clinically appropriate behavioral health services within the scope of their training and/or practice.

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

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

Community First's Care Management staff is available to assist in identifying and accessing behavioral health providers that can meet the needs of a CHIP Member. We encourage you to call us with any questions regarding behavioral health services at **(210) 358-6100** or **1-800-434-2347**.

Medical Records Documentation and Referral Information

When assessing a CHIP Member for behavioral health services, Providers must use the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Community First may require use of other assessment instruments/outcome measures in addition to the DSM-V. Providers must document DSM-V and the assessment/outcome information in the CHIP Member's medical record.

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

Consent for Disclosure of Information

A written medical record release must be obtained from the CHIP Member, or a parent or legal guardian of the CHIP Member, before the Provider can send the CHIP Member's Behavioral Health Report to the PCP. The CHIP Member will be advised that they are not required to sign the release and treatment will not be denied if the CHIP Member objects to signing the form. The Provider will place a copy of the signed release in the CHIP Member's record.

Court-Ordered Commitments

Community First must provide inpatient psychiatric services to CHIP Members under the age of 21 whom the court of competent jurisdiction has ordered to receive the services under the provision of Chapter 573 and 574 of the Texas Health and Safety Code, which relates to court ordered commitments to psychiatric facilities.

Community First cannot deny, reduce or controvert the medical necessity of any court ordered inpatient psychiatric service for CHIP Members under age 21. Any modification or termination of court ordered services for CHIP Members must be presented to the court with jurisdiction over the matter to make a determination.

A CHIP Member who has been ordered to receive treatment under the provisions of Chapter 573 and 574 of the Texas Health and Safety Code **cannot** appeal the commitment through Community First complaint and appeals process.

Coordination with the Local Mental Health Authority

Providers rendering behavioral health services who believe CHIP Members qualify for targeted case management or rehabilitation services through the Local Mental Health Authority (LMHA) may refer the Member to the LMHA office nearest to the CHIP Member. The LMHA will assess the CHIP Member to determine if they meet criteria for Severe and Persistent Emotional Disturbance (SPMI) or Severe Emotional Disturbance (SED). Contact Community First by calling **(210) 358-6100** for a list of LMHAs in your area.

A Provider, with written consent from the CHIP Member, should inform the LMHA providing rehabilitation services or target case management that the CHIP Member is receiving behavioral health services.

Behavioral Health Assessment Instruments Available for PCP Use

Community First requires, through provisions in its Professional Provider Agreement, that a Member's PCP have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their training and practice.

Community First will provide or arrange for training for network PCPs on how to screen and identify behavioral health disorders, and the referral process for behavioral health services and clinical coordination requirements for such services. Community First will also provide general assessment tools for PCPs as they are developed.

Focus Studies and Utilization Management Reporting Requirements

As part of the Utilization Management Report submitted by Community First to HHSC on a quarterly basis, Community First includes behavior health utilization data. Each report has a standardized reporting format and detailed instructions that DSHS may periodically update to include new codes, which will allow for better communication between Community First and HHSC.

To meet this reporting requirement, Community First might include Providers who render behavioral health services to CHIP Members in a behavioral health medical record audit.

Procedure to Follow Up on Missed Appointments

Community First requires that all Providers contact CHIP Members, if they miss a scheduled appointment, and reschedule such appointment within 24 hours of said missed appointment.

Discharge Planning and Aftercare

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

Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. **The outpatient treatment must occur within seven (7) days from the date of discharge**. Behavioral health providers must contact Members who have missed their appointment within 24 hours to reschedule said appointment.

Summary Reports to Primary Care Providers

All Providers rendering behavioral health services to CHIP Members must send completed Behavioral Health Reports to the PCP upon beginning behavioral health services and every three (3) months that the CHIP Member remains in treatment and/or upon discharge. A copy of the report will be placed in the CHIP Member's permanent record.

5. Emergency Behavioral Health Services

Emergency behavioral health conditions include emergency detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code.

In the event of a behavioral health emergency, the safety of the Member and others is paramount. The Member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the Member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the Member is any of the following:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol-or-drug-dependent with signs of severe withdrawal

Community First does not require precertification or notification of emergency services, including emergency room and ambulance services. If the Member can't be seen within six (6) hours of initial contact, then the Member should be referred to the ED.

6. Behavioral Health Value-Added Services

Value-Added Service	Limitations
Healthy Mind: Behavioral Health Management Program	Home visits for high-risk Members enrolled in Healthy Mind.
Dedicated Resources Page for Young Minds to learn the warning signs of mental illness	
Inpatient follow-up incentive program	$25 gift card for Members who attend follow-up appointment after leaving a behavioral health hospital. Must attend appointment within seven days of discharge. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.

E. Emergency, Urgent, and Routine Care Services

1. Definitions of Emergency, Urgent, and Routine Care

Emergency Care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent

onset and severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the CHIP Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in the following:

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

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

When the condition of the CHIP Member requires use of special equipment, life support systems, and close monitoring by trained attendants while **en route** to the nearest appropriate facility, the ambulance is an emergency service. If a CHIP Member needs to be transferred to another facility and the medical condition of the CHIP Member requires immediate medical attention, the transfer may be considered as an emergency transfer.

Community First should be notified of admissions or procedures within 24 hours, or the next business day.

If it is determined that a medical emergency does not exist (emergency care is not rendered), the CHIP Member must contact his or her PCP to arrange any non-emergency care needed. If the CHIP Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the CHIP Member may be transferred to a network hospital as soon as stabilization occurs, and the attending Provider deems it medically appropriate. Once the patient/Member is stabilized, the treating Provider is required to contact Community First to obtain authorization for any necessary post-stabilization services. Community First will process all requests for authorization of post-stabilization services within one (1) hour of receiving the request.

An **urgent condition** means a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the CHIP Member's PCP or PCP designee to prevent serious deterioration of the CHIP Member's condition or health.

Urgent Admission Notification Process

- Unplanned Admissions Requirements: Community First requires urgent admission notification within 24 hours of admission. Facilities are to submit supporting clinical information within 48 hours of the admission. Observation stays do not require authorization.

- Documentation Requirements: Supporting documentation includes but is not limited to the physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required.

If additional information is later required for concurrent review, facilities are to submit requested information within 24 hours of request.

For after-hours urgent care, and certain instances during normal office hours, Community First Members can visit network urgent care centers listed in the Provider Directory. In addition, Members can call our **24/7 Nurse Advice Line at (210) 358-3000 or 1-800-434-2347**, a nurse advice service staffed by Registered Nurses who provide advice according to written protocols and assist CHIP Members in accessing treatment.

Urgent Care Referral During Normal Office Hours

You may refer a patient to an urgent care clinic during normal office hours only if the PCP is unavailable, and a triage nurse has determined that the patient requires urgent care, **not hospital emergency care**. The PCP's nursing staff should triage the patient or refer to the Nurse Advice Line if the PCP's nursing staff is unavailable.

If the examining physician determines that a **true medical emergency exists**, the CHIP Member will be admitted to the nearest hospital emergency department appropriate for the patient's condition. If a **medical emergency does not exist**, but the examining physician determines that hospitalization is necessary for further evaluation and/or

treatment, the PCP will be contacted to affirm concurrence in admitting the patient. It will then be the PCP's responsibility to arrange admission to a Community First network hospital.

Routine/Non-Emergent Condition

A routine/non-emergent condition is a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

2. Emergency Transportation

According to 1 TAC §354.1111, an emergency transport is a service provided by a CHIP-enrolled ambulance provider for a CHIP Member whose condition meets the definition of an emergency medical condition. Conditions requiring cardiopulmonary resuscitation (CPR) in transit or the use of above routine restraints for the safety of the client or crew are also considered emergencies. Facility-to-facility transfers are appropriate as emergencies if the required emergency treatment is not available at the first facility.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, and loss of consciousness, semi consciousness, and seizure or with receipt of CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria.

Emergency transports do not require prior authorization.

3. Member/Client Acknowledgment Statement

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

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

- The patient requests the specific service.
- The Provider obtains a **Member/Client Acknowledgment Statement (Exhibit 13)** signed by the patient and the Provider.

NOTE: A Provider is allowed to bill the following to a client without obtaining a signed Member/Client Acknowledgment Statement:

- Any service that is not a benefit of the Texas CHIP Program (e.g., personal care items).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days.
- The reduction in payment that is because of the medically needy spend down (effective September 1, 2003, the Medically Needy Program (MNP) is limited to children younger than age 19 years and pregnant women). The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the Provider accepts the client as a private pay patient, the Provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the Provider to ensure that the client signs written notification so there is no question how the client was accepted.

4. Private Pay Form Agreement

A participating physician and/or Provider may bill a CHIP Member only if:

- A specific service or item is provided at the CHIP Member's request.
- The Provider has obtained and kept a written **Private Pay Agreement (Exhibit 18)** signed by the client.

The Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay Agreement from the CHIP Member. Without written, signed documentation that the CHIP Member was properly notified of the private pay status, PCP and/or participating provider cannot seek payment from an eligible CHIP Member.

If the Member is accepted as a private pay patient pending CHIP eligibility determination and the Member does **not** become eligible for CHIP retroactively. The PCP and/or participating Provider are allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactive, the Member will notify the Provider of the change in status. Ultimately, the Provider is responsible for filing claims timely to Community First. If the Member becomes eligible, the Provider **must** refund any money paid by the client and file claims for all services rendered to Community First, if appropriate.

A Provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from the Texas CHIP Program and termination from network participation with Community First.

IMPORTANT: Ancillary services must be coordinated, and pertinent eligibility information must be shared. The PCP is responsible for sharing eligibility information with others.

5. Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the Member's medical condition. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should contact Navitus Health Solutions' Provider Hotline at **1-877-908-6023.**

Call **210-358-6294** for more information about the 72-hour emergency prescription supply policy.

6. Emergency and Non-Emergency Dental Services

Emergency Dental Services

Community First is responsible for emergency dental services provided to CHIP and CHIP Perinate Newborn Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin.

Non-Emergency Dental Services

Community First is **not responsible** for paying for routine dental services provided to CHIP Members. These services are paid through Dental Managed Care Organizations.

Community First **is responsible** for paying for treatment and devices for craniofacial anomalies.

F. Provider Responsibilities

1. Primary Care Provider (Medical Home) Responsibilities

Primary care providers (PCP) function as the Medical Home for Community First CHIP Members.

PCP means a physician or provider who has agreed with the MCO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Medical Home means a PCP practice, or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and Provider satisfaction under CHIP the medical assistance program.

To participate in the CHIP Program, a Provider, with an agreement with HHSC or its agent, must have a Texas Provider Identification Number (TPIN). CHIP Providers also must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2008).

Role of Medical Home

CHIP Medical Homes must provide six core services:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care/follow-up
4. Patient and family support
5. Referral to community and social support services
6. Use of health information technology to link services

Integrating Physical Health/Behavioral Health in Medical Homes

CHIP Medical Homes provide states with an important opportunity to integrate physical and behavioral health care for beneficiaries with complex care needs. Although states have considerable flexibility to define Medical Home services and Provider qualification as they see fit, effective integration of physical and behavioral health services is a critical aspect of program design.

PCP Responsibilities

PCPs are responsible for reporting suspected child abuse or neglect. At the request of HHSC and The Department of Family and Protective Services (DFPS), Providers must testify in court as needed for child protection litigation.

Providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including:

- Providing medical records.
- Recognition of abuse and neglect, and appropriate referral to DFPS.

PCPs are responsible for arranging and coordinating appropriate referrals to other Providers and specialists, and for managing, monitoring, and documenting the services of other Providers. PCPs must:

- Comply with applicable state laws, rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and
- Otherwise conduct themselves in a businesslike and professional manner

PCPs are responsible for the appropriate coordination and referral of Community First CHIP Members for the following services:

- MR targeted case management
- Texas Commission for the Blind case management services
- Well-child exam medical
- Well-child exam dental
- Tuberculosis services
- Community First's pharmacy program through Navitus

2. Availability and Accessibility

Network PCPs must be accessible to CHIP Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

Acceptable Phone Arrangements

a. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and whish can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

b. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's phone. A second recorded message is not acceptable.

c. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the PCP or another designated Provider.

Unacceptable Phone Arrangements

a. The office phone is only answered during office hours.

b. The office phone is answered after hours by a recording, which tells patients to leave a message.

c. The office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.

Updates to Contact Information

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

Access and Availability Standards

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

opportunities to improve our performance, and to develop and implement intervention strategies to affect any necessary improvement.

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

Community First Providers must be available to Members by telephone 24 hours a day, 7 days a week for consultation and/or management of medical concerns.

PRIMARY CARE PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
Emergency Care, including Behavioral Health	24 hours a day, 7 days a week, upon Member presentation at the delivery site, including non-network and out-of-area facilities
Urgent Care (PCP) (Specialist) (Behavioral Health)	Within 24 hours of request Within 24 hours of request Within 24 hours of request
Routine Care (PCP) (Specialist) (Behavioral Health)	Within 14 days of request Within 14 days of request Within 14 days of request
Routine/Scheduled Inpatient/Outpatient Care	Within 14 days of request
Behavioral Health Discharge Planning/Aftercare	Members discharged from an impatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments.
Initial Outpatient Behavioral Health Visits	Within 14 days of request
Routine Specialty Care Referrals	Within 21 days of request
Physical Examinations	56 days or less (4 to 8 weeks)
Prenatal Care (Initial)	14 calendar days or less or by the 12th week of gestation. Members who express concern about

PRIMARY CARE PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
	termination will be addressed as Urgent Care.
High-risk pregnancies or new Members in the third trimester	Within 5 days or immediately if an emergency exists.
Well-Child Care Routine Well-Child Care Routine Well-Adolescent Care	 Within 14 days of request Within 14 days of request
Well Child Exam	Within 14 days of request
Children of Traveling Farm Workers	Staff must ensure prompt delivery of services to children of traveling farm workers and other migrant populations who may transition into or out of HMO program more rapidly and/or unpredictably than the general population.
Newborn Care (in a hospital)	Newborns must receive an initial newborn checkup before discharge from the hospital to include all required tests and immunizations.
Newborn Care (after discharge from a hospital)	Within 3 to 5 days after birth and then within 14 days of hospital discharge.
Preventive Health Services for Children and Adolescents	Within 14 days of request
Preventive Health Services for Adults	Within 90 days of request in accordance with U.S. Preventive Service Task Force recommendations
Physical Therapy (Routine) (Urgent) (Follow-up)	3 days or less Within 24 hours 14 days or less
Radiology (Urgent) (MRI/CT Scan) (IVP/UGI) (Mammogram)	Within 24 hours 7 days or less 10 days or less 21 days or less

PRIMARY CARE PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within 2 hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection.
Provider Office Waiting Time	Within 30 minutes of scheduled appointment time.
Requests for Feedback from Pharmacy Related to Prescriptions	Within 24 business hours

3. Plan Termination Process

Community First or the participating Provider may terminate their contractual agreement as of any date by giving written notice of at least sixty (60) days in advance. The parties may, however, agree to an earlier termination date. Community First may also terminate this agreement immediately upon notice to the Provider in the event of Community First's determination that the health, safety or welfare of any CHIP Member may be in jeopardy if the agreement is not terminated. Providers may refer to the Term and Termination section of their Professional Provider Agreement for more information.

The Provider's contract contains Community First's process for termination.

Community First follows the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider, including an STP. At least 90 days before the effective date of the proposed termination of the Provider's contract, Community First will provide a written explanation to the Provider of the reasons for termination. Community First may immediately terminate a Provider contract in a case involving

a. Imminent harm to patient health.
b. An action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency, that

effectively impairs the Provider's ability to practice medicine, dentistry, or another profession.

c. Fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, a Provider may request a review from Community First proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and Providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee from Community First. The decision of the advisory review panel must be considered by Community First but is not binding of Community First. Within 60 days following receipt of the Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Community First will communicate its decision to the Provider. Community First will provide to the affected Provider, upon request, a copy of the recommendation of the advisory review panel and Community First's determination.

Termination for Gifts or Gratuities

Providers may not offer or give anything of value to an officer or employee of HHSC or the state of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the Provider contract at any time for violation of this requirement.

4. Member's Right to Designate an OB/GYN

Community First does not limit the selection of an OB/GYN to the PCP's network.

Female Members have the right to select an OB/GYN without a referral from their PCP. The access to health care services of an OB/GYN includes:

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

5. Optometry and Ophthalmology Services

Members have the right to select and have access to, without a PCP referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery.

6. Access to Medication

Members have the right to obtain medication from any network pharmacy.

7. How to Help a Member Find Dental Care

The Dental Plan Member ID card will list the name and phone number of a Member's Main Dental Home Provider. The Member can contact the dental plan to select a different Main Dental Home Provider at any time. If the Member selects a different Main Dental Home Provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within five (5) business days.

If a Member does not have a dental plan assigned or is missing their ID card from a dental plan, the Member can contact the CHIP enrollment broker toll-free at **1-800-964-2777**.

8. Advance Directives

The Provider must comply with the requirements of state and federal laws, rules, and regulations relating to advance directives.

It is the Member's right to accept or refuse medical care. An advance directive can protect this right if they ever become mentally or physically unable to choose or communicate their wishes due to an injury or illness. To request additional information or to request a brochure about advance directives, the Member can contact Member Services at **(210) 358-6060** or toll-free at **1-800-434-2347**.

9. Referral to Specialists and Health-Related Services

PCPs are responsible for assessing the medical needs of CHIP Members for referral to specialty care providers and to provide referrals as needed. The PCP must coordinate Members' care with the specialty care providers after referral. Community First will assess PCP's actions in arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers. CHIP dual-eligible Members are excluded.

10. PCP and Behavioral Health Related Services

A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his or her training and/or practice.

11. Referral to Network Facilities and Contractors

The PCP or specialist may directly refer a Member for services that do not require preauthorization. All referrals must be to a Community First network Provider. Community First's Provider network may occasionally change. Contact the Provider Relations Department at **(210) 358-6294** for current Provider information. Use of a non-participating provider requires preauthorization by Community First. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care.

Community First requires preauthorization for court mandated inpatient psychiatric care for CHIP Members. Community First will not, however, deny, reduce or controvert the medical necessity of any physical or behavioral health

care services included in an order entered by the court with respect to a child in the conservatorship of the Texas Department of Child Protective Services.

NOTE: Payment for services requiring notification or preauthorization is contingent upon verification of current eligibility and applicable contract specifications at the time of service. For verification of eligibility, call **(210) 358-6403**.

12. Access to a Second Opinion

Members have access to a second medical opinion from a network Provider or an out-of-network provider at no additional cost to the Member if a network Provider is not available.

13. Specialty Care Provider Responsibilities

Availability and Accessibility

Network specialists must be accessible to CHIP Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network specialists after normal business hours.

Acceptable Phone Arrangements

a. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and who can contact the specialist or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

b. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach the specialist or another network Provider designated by the specialist. Someone must be available to answer the designated network Provider's phone. A second recorded message is not acceptable.

c. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the specialist or another designated network Provider.

Unacceptable Phone Arrangements

a. The office phone is only answered during office hours.

b. The office phone is answered after hours by a recording, which tells patients to leave a message.

c. The office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.

SPECIALTY PROVIDER ACCESS STANDARDS	
Type of Appointment	**Appointment Availability**
Emergency Care, including Behavioral Health	24 hours a day, 7 days a week, upon Member presentation at the deliver site, including non-network and out-of-area facilities.
Urgent Care (PCP) (Specialist) (Behavioral Health)	 Within 24 hours of request Within 24 hours of request Within 24 hours of request
Routine Care (PCP) (Specialist) (Behavioral Health)	 14 days or less of request 14 days or less of request 14 days or less of request
Routine/Scheduled Inpatient/Outpatient Care	14 days or less of request
Behavioral Health Discharge Planning/Aftercare	Members discharged from an impatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments
Initial Outpatient Behavioral Health visits	Within 14 days of request
Routine Specialty Care Referrals	Within 21 days of request

SPECIALTY PROVIDER ACCESS STANDARDS	
Physical Examinations	56 days or less (6-8 weeks)
High-risk pregnancies or new Members in the third trimester	Within 5 days or immediately if an emergency exists
CHIP Well-Child Care Routine Well-Child Care Routine Well-Adolescent Care	 Within 14 days of request Within 14 days of request
Newborn Care (in a hospital)	Newborns must receive an initial newborn checkup before discharge from the hospital
Newborn Care (after discharge from a hospital)	Within 14 days of hospital discharge
Preventive Health Services for Children and Adolescents	Within 14 days of request
Preventive Health Services for Adults	Within 90 days of request in accordance with US Preventive Services Task Force recommendations
Physical Therapy (Routine) (Urgent) (Follow Up)	 3 days or less Within 24 hours 14 days or less
Radiology (Urgent) (MRI/CT Scan) (IVP/UGI) (Mammogram)	 Within 24 hours 7 days or less 10 days or less 21 days or less
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within 2 hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection.
Provider office waiting time	Within 30 minutes of scheduled appointment time.
Request for feedback from pharmacy related to prescriptions	Within 24 business hours

14. Verifying Member Eligibility and/or Authorization for Services

All reimbursement is subject to eligibility and contractual provisions and limitations.

Each CHIP/CHIP Perinate Newborn Member is issued a **Your Texas Benefits Medicaid Card (Exhibit 2)**, and either a **Community First CHIP Member ID Card (Exhibit 3a)** or **Community First CHIP Perinate Newborn Member ID Card (Exhibit 3b)**. Members are instructed to present both their Medicaid card and their Community First Member ID card when requesting services. The Community First Member ID card includes important Member information and Community First telephone numbers.

A Member's Community First ID card does not guarantee eligibility for coverage. To verify eligibility:

- Call Member Services at **(210) 358-6300** or **1-800-434-2347**
- Visit CommunityFirstMedicaid.com and log into the Provider Portal

If a Member has questions about benefits or coverage or wants to change their PCP, please ask them to call Member Services at **(210) 358-6300**.

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

- **Inpatient admissions prior to enrollment with Community First.** Community First is responsible for physician and non-hospital services from the date of enrollment with Community First. Additionally, Community First is not responsible for any hospital charges for Members admitted prior to enrollment with Community First.

- **Inpatient admissions after enrollment with Community First.** Community First is responsible for services until they discharge the CHIP Member from the hospital unless the Member loses CHIP eligibility.

- **Discharge after voluntary disenrollment from Community First and re-enrollment into a new CHIP HMO.** Community First remains responsible for hospital charges until the CHIP Member is discharged from the facility.

The new CHIP HMO is responsible for physician and non-hospital charges beginning on the effective date of enrollment into the new CHIP HMO.

- **CHIP Perinate Newborns.** Community First is responsible for all covered services related to the care of a CHIP Perinate Newborn child from the date of birth, if the mother is enrolled with the Community First Perinate program at the time of birth.

- **Hospital Transfers.** Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment should not be considered as discharged under this section.

- **Psychiatric Care.** Inpatient psychiatric care, in a freestanding psychiatric facility for CHIP Members under age 19, is Community First's responsibility from the Member's date of enrollment with Community First.

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

The PCP is responsible for initiating all referrals to specialty care providers (see section on Referral Notification).

Community First currently requires preauthorization for certain services. Please review the Prior Authorization List for a list of these services.

The list of services requiring preauthorization is subject to change. Community First will provide at least 90 days' notice of changes in the list of authorized services.

If the Provider seeking authorization is a specialty physician, communication must be provided to the PCP regarding services rendered, results, reports and recommendations to ensure continuity of care.

NOTE: Preauthorizations are generally valid for 30 days from the date issued. This timeframe may be extended based on the type of request. Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If preauthorization expires, call Community First.

All services listed on the preauthorization list will be subject to medical necessity review in advance of the services being rendered. Failure to obtain preauthorization in advance of the service being rendered will result in an administrative denial of the claim. Providers cannot bill CHIP Members for covered services.

PCPs and specialists may request preauthorization as follows:

- Call Community First's Population Health Management Department at **(210) 358-6050**.

- Fax the completed **Texas Standard Prior Authorization Request for Health Care Services Form (Exhibit 6)** to **(210) 358-6040**.

- Submit secure electronic requests using the Provider Portal. (Contact Community First Provider Relations at **(210) 358-6294** or email ProviderRelations@cfhp.com for help registering.)

The Population Health Management Department is available to answer preauthorization requests from 8:30 a.m. to 5:00 p.m., CST. After hours and on weekends or holidays we will accept either your fax or phone message as meeting notification requirements, however, authorization of the services listed on the preauthorization list will need to meet eligibility, medical necessity review, and benefit criteria prior to issuance of an authorization number. You may call Community First to check on the status of your preauthorization request at **(210) 358-6050** during regular business hours.

Please have the following information available when requesting preauthorization:

- Member's name and ID number
- Primary diagnosis with ICD-10 code, if known
- Surgery/procedure with CPT code, or purpose and number of visits
- Anticipated date of service or admission date
- Name of consultant/facility
- Clinical information to support the requested service
- Expected length of stay (inpatient only)

Population Health Management will issue an authorization number for approved requests after eligibility, medical necessity, and benefit criteria has been determined. Faxed requests will be faxed back to the requesting Provider

including the authorization number if the service/s has been approved. Telephone requests will receive an authorization telephonically if the service(s) is approved.

If a request is pending because information is incomplete, the Provider will be contacted. Once we receive the required information, we will either approve the request or send the information to the Community First Medical Director for final review. If we do not receive the required information, the service(s) will be denied by the Medical Director or Clinical Consultant for lack of requested information.

Community First will deny requests that do not meet eligibility, benefit criteria, or medical necessity criteria. Community First will afford the requesting Provider reasonable opportunity to discuss with the Medical Director or Clinical Consultant the plan of treatment and the clinical basis for the decision, as well as the opportunity to provide additional information that may be pertinent prior to the issuance of an adverse determination. We will notify the Provider by phone and letter, either by fax or mail, within 48 hours. The CHIP Member will also be sent a denial letter by mail. If the authorization request is denied based on medical necessity, the Provider can appeal the decision on behalf of the Member. Appeal information will be included in the denial letter.

15. Continuity of Care

Continuity of Care for Pregnant Women

Pregnant Members with 12 weeks or less remaining before their expected delivery date extending through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery will be allowed to stay under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is out of network. If the Member wants to change her OB/GYN to one who is in the plan, she will be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester. The Provider must complete the **Request for Continuity/Transition of Care (Exhibit 1).**

Continuity of Care for Members that Move Out of Service Area

Community First will reimburse out-of-network providers for covered services rendered to CHIP Members who move out of Community First's service area

through the end of the period for which a premium has been paid for the Member.

Preauthorization must be obtained for all out-of-network services. Requests for preauthorization can be submitted to Community First's Population Health Management Department by fax to **(210) 358-6040** or by phone at **(210) 358-6050.**

Continuity of Care for Pre-Existing Conditions

Community First is responsible for arranging for the provision of all covered CHIP services to each eligible Community First CHIP Member beginning on the CHIP Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services; health status; confinement in a health care facility; or for any other reason. All arrangements for covered CHIP services will be in accordance with contractual requirements between Community First and the Provider.

16. Transition and Continuity of Care

Community First will ensure that the care of newly enrolled Community First CHIP Members is not unreasonably disrupted or interrupted to the magnitude that the CHIP Member's health could be placed in jeopardy if such care is disrupted or interrupted. Community First provides CHIP Members with a process to request continuation/transition of ongoing care and use of a specialist as the PCP under certain circumstances. Through collaboration with Community First's Care Managers, CHIP Members with medical or behavioral disabilities or chronic/complex conditions are encouraged to maintain a stable "Medical Home."

17. Justification for Out-of-Network Authorizations

Community First's requirements concerning treatment of Members by out-of-network providers are as follows:

a. Community First will allow referral of its Member(s) to an out-of-network provider; issue the proper authorization for such referral in a timely manner; and timely reimburse the out-of-network provider for authorized services provided when:

- CHIP covered services are medically necessary, and these services are not available through an in-network Provider.

- A Provider currently providing authorized services to the Member requests authorization for such services by an out-of-network provider.

- The authorized services are provided within the time period specified in the authorization issued by Community First. If the services are not provided within the required time period, a new request for preauthorization from the requesting Provider must be submitted to Community First prior to the provision of services.

b. Community First may not refuse to reimburse an out-of-network provider for emergency or post-stabilization services provided as a result of the Community First failure to arrange for and authorize a timely transfer of a Member to an in-network facility.

c. Community First's requirements concerning emergency services are as follows:

- Community First must allow its Members to be treated by any emergency services provider for emergency services and/or for services to determine if an emergency condition exists.

- Community First is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

d. Community First may be required by contract with HHSC to allow Members to obtain services from out-of-network providers in circumstances other than those described above.

Reasonable Reimbursement Methodology

Community First has been reimbursing out-of-network providers in accordance with Texas Administrative Code (TAC) at Title 1, Part 15, Chapter 355:

- For a date of service on or after February 20, 2010 out-of-network/in-area providers were reimbursed at CHIP minus 5% in accordance with the change in Texas Administrative Code (TAC) at Title 1, Part 15, Chapter 355.

- Out-of-network/out-of-area providers requesting reimbursement at 100% of CHIP rates are considered if a timely request for authorization is obtained, which includes the requirement to request 100% of the CHIP rate at the time of the request for authorization. If the service(s) are approved, the request for the 100% CHIP rate will be forwarded to Provider Relations to address the requested rate with the Provider.

18. Coordination with Texas Department of Family and Protective Services (DFPS)

The Provider must cooperate and coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS, including:

- The report of any confirmed or suspected cases of abuse and neglect to DFPS
- The provision of medical records at the time the records are requested

Community First will continue to provide all covered services to a CHIP Member receiving services from or in the protective custody of DFPS until the CHIP Member has been disenrolled from Community First as a result of loss of eligibility or placement into foster care.

G. Member Eligibility and Enrollment

1. Member Eligibility

Member eligibility guidelines are as follows:

- 12-month eligibility for CHIP Program Members

- A CHIP Perinate Newborn who lives in a family with an income at or below the Medicaid Eligibility Threshold of the Federal Poverty Level (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and

moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

- A CHIP Perinate Newborn will continue to receive coverage through the CHIP Program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid Eligibility Threshold of the Federal Poverty Level and the birth is reported to HHSC's enrollment broker.

- A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinate health plan.

These determinations are made by HHSC.

Verifying Eligibility

Each CHIP/CHIP Perinate Newborn Member is issued an identification card and is instructed to present the Community First ID card when requesting medical services. The **Community First CHIP Member ID Card (Exhibit 3a)** and **Community First CHIP Perinate Newborn Member ID Card (Exhibit 3b)** includes important Member information such as Community First telephone numbers and the CHIP Member's assigned PCP. Providers may contact Community First by telephone to verify Member eligibility by calling **(210) 358-6300**.

A Member who appears on a PCP's monthly Member Roster is considered to be an existing Member from the first month that they appear on the roster and therefore cannot be refused services while assigned to that PCP. The Community First ID card, however, may not guarantee eligibility for coverage.

If a CHIP/CHIP Perinate Newborn Member has selected a PCP who is part of a Limited Provider Network, you may not see that Member unless you have written authorization from the Limited Provider Network. Any services, with the exception of emergencies, will not be reimbursable.

Confirming eligibility before rendering services is essential. Listed below are helpful ways to confirm eligibility:

- Call Member Services at (**210) 358-6300** or toll-free at **1-800-434-2347.**

- Login to Community First's Provider Portal at CommunityFirstMedicaid.com.

- Electronic Eligibility Verification (e.g., NCPDP E1 transaction) (available to pharmacies).

Pregnant Teens

CHIP Members should contact Community First Member Services as soon as they are aware of their pregnancy. A Provider, as well, is required to contact Community First immediately when a pregnant CHIP Member is identified.

Span of Eligibility

Community First will arrange for all covered services for the period CHIP/CHIP Perinate Newborn Members are eligible. Eligibility is spanned in 12-month increments. Determination of eligibility is assumed by HHSC.

2. Member Enrollment, Re-enrollment, and Disenrollment

Enrollment (12-Month Eligibility)

To enroll in Community First, the Member's permanent residence must be located within Community First's service area. HHSC will electronically transmit to Community First new Member information, PCP selections, and any change of information applicable to active Members five (5) business days prior to the first day of each month.

NOTE: Twelve (12) months of continuous coverage begins on the first day of the month following enrollment, unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month.

Newborn Enrollment Process

All Members of the household must remain in the same health plan until the latter of the following:

- The end of the CHIP Perinate Newborn Member's enrollment period, or

- The end of the traditional CHIP Program Member's enrollment period.

Copayments, cost-sharing, and enrollment fees still apply to a child enrolled in the CHIP Program.

In the tenth (10th) month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. Once the child's CHIP Perinate service coverage expires, the child will be added to their siblings' existing CHIP program cases.

Re-Enrollment

At the beginning of the fifth (5th) month of coverage, the HHSC will send a note to the family outlining the next steps for renewal or continuation of coverage. HHSC also will send a notice to Community First regarding its Members and to a community-based outreach organization providing follow-up assistance in the Members' area. To promote the continuity of care for children eligible for re-enrollment, Community First may facilitate re-enrollment through reminders to Members and other appropriate means. Failure of the family to respond to the HHSC's renewal notice will result in disenrollment from Community First and from CHIP/CHIP Perinate Program.

Disenrollment

CHIP Members can be disenrolled from CHIP or CHIP Perinate Newborn for any of the following reasons:

- "Aging-out" when a child turns 19.
- Change in health insurance status, such as a child enrolling in an employer-sponsored health plan.
- Failure to meet monthly cost sharing obligation.
- Death of a child.
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP/CHIP Perinate.

- Immigration.
- Increased income.
- Provisional eligibility term.
- Health plan change.
- No longer CHIP/CHIP Perinate-eligible.
- Child left household.

Community First has the limited right to request disenrollment of CHIP/CHIP Perinate Members from our health plan. HHSC will make the final decision on any request by Community First for such disenrollment.

The CHIP Member may request the right to appeal such a decision. The PCP will be responsible for directing the CHIP Member's care until the disenrollment is made. Request to disenroll a Community First CHIP Member **is acceptable** under the following circumstances:

- The CHIP Member misuses or lends his/her Community First Member ID card to another person to obtain services.
- The CHIP Member is disruptive, unruly, threatening, or uncooperative to the extent that the CHIP Member seriously impairs Community First's or a Provider's ability to service the CHIP Member. However, this only occurs if the CHIP Member's behavior is not due to a physical or behavioral health condition.
- The CHIP Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First to arrange for the treatment of the underlying medical condition.
- The Member's disenrollment request from managed care will require medical documentation from the primary care provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

The Provider cannot take retaliatory action against Member. The Member's disenrollment request will require medical documentation from the PCP or documentation that indicated sufficiently compelling circumstances that merit disenrollment.

Plan Changes

CHIP Members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in the CHIP Program.
- If the Member moves into a different services area.
- For cause at any time.
- During the annual re-enrollment period.

H. Special Access Requirements

1. Interpreter/Translation Services

Community First Member Services is staffed by representatives who can speak to Members in English or Spanish. Member Services can also arrange for an interpreter who speaks their language.

Community First has interpretive services available for its CHIP Members to ensure effective communication regarding treatment, medical history, or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide Community First CHIP Members access to professionals trained to help with technical, medical, or treatment information when a family Member or friend interpreter is inappropriate. To arrange for a sign interpreter or language interpreter for a Community First CHIP Member, please contact Community First's Member Services at **(210) 358-6300**.

2. Community First and Provider Coordination

Community First will make every effort to communicate with and coordinate the delivery of covered services with a CHIP Member's PCP. Community First will provide each PCP and his/her staff with a current Provider Manual and revisions within five (5) days of becoming network participants. Provider orientations will be completed within 30 days of the PCP becoming a network participant. Additionally, routine office visits will be made by assigned Provider Relations representative to answer any questions or concerns and to review critical elements with the physician and their staff.

Community First will operate a Provider Relations telephone line specifically for Providers from 8:30 a.m. to 5:00 p.m. (CST), Monday through Friday. The Provider Relations line will be staffed with personnel who are knowledgeable about covered services for CHIP, about non-capitated services, and general health plan operations to assist the Provider.

3. Reading/Grade Level Consideration

Community First prints all CHIP Member materials in both English and Spanish at a sixth grade reading comprehension literacy level.

4. Cultural Sensitivity

Community First recognizes the diversity of the population in the CHIP Program and has programs to support a multicultural membership. We staff Community First's Member Service Department with knowledgeable, bilingual (English/Spanish) Member Service Representatives to help CHIP Members with questions.

3. Children with Complex and Special Health Care Needs

The PCP for a CHIP Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all the PCP duties required as outlined in the Provider Manual and the Professional Provider Agreement and within the scope of the specialist's license.

Any interested person may initiate the request to Community First for a specialist to serve as a CHIP Member who is disabled, has a Special Health Care Needs, or Chronic or Complex Condition. Community First shall handle the request as outlined in its

policy (Specialist Physician as Primary Care Physician, # 500.17) which is in compliance with 28.TAC Part 1, Chapter11, Subchapter J.

I. CHIP Member Rights and Responsibilities

1. CHIP Member Rights

a. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

b. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."

c. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

d. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

e. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

f. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

g. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.

h. Children who are diagnosed with special health care needs or a disability have the right to special care.

i. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

j. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

k. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment, depending on your income. Co-payments do not apply to CHIP Perinate Members.

l. You have the right and responsibility to take part in all the choices about your child's health care.

m. You have the right to speak for your child in all treatment choices.

n. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

o. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.

p. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

q. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have

another group, outside the health plan, tell you if they think your doctor or the health plan was right.

r. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

s. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

2. CHIP Member Responsibilities

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

a. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

b. You must become involved in the doctor's decisions about your child's treatments.

c. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

d. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

e. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

f. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

g. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.

h. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other Members, or health plans.

i. Talk to your child's provider about all of your child's medications.

J. Preventive Health and Disease Management

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

Provider Referral

Providers are encouraged to inform CHIP Members about the health education services available through Community First. When an education or social need is identified, one can refer a CHIP Member to the Preventive Health and Disease Management Department in one of the following manners:

Mail in the **Member Education Request Form (Exhibit 11)** to the following address:

Community First Health Plans
Provider Relations
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

You can also fax the Member Education Request Form to **(210) 358-6199**, call a Community First Health Educator at **(210) 358-6055** or email healthyhelp@cfhp.com.

Community First New Member Assessment Program

Outreach is initiated to each new CHIP Member to detect health risk factors, potential participation in population-based initiatives or disease management programs, and to assess barriers to care. Educational information and resource information is given to Members, including social services resources. Common CHIP Member concerns include transportation, utilities, and nutritional resources. Although not all social concerns are directly related to their medical care, frequently these issues affect access to care, continuity of care, and compliance with treatment plan. Community First works to assist CHIP Members in addressing these concerns to promote wellness. Information gathered from the

Member is forwarded to the PCP for review, potential outreach, and inclusion in the medical record.

Health Education Services

Health education is available through classes, educational mail outs, and individualized outreach visits. Several initiatives have been developed to educate CHIP Members and promote involvement in self-care behaviors. Participation in disease management and health promotion initiatives is free-of-charge and Members may opt out at any time. Overall program goals include increased education regarding disease processes and management, establishment of a collaborative physician-patient relationship, appropriate utilization of health care resources, increased quality of life, and CHIP Member satisfaction and retention. Program participation information is routinely mailed to the PCP for review and inclusion in the CHIP Member's medical record.

1. Diabetes in Control: Diabetes Management Program

Per the CDC's National Diabetes Statistics Report of 2020, 34.1 million adults ages 18 and older in the United States have diabetes (13 percent of the U.S. population). More than 7.3 million of these are undiagnosed (21.4 percent of people with diabetes are undiagnosed). In Bexar County, in 2018, 15.5 percent of the population had been diagnosed with diabetes.

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

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

Members enrolled in the **Diabetes in Control** program receive ongoing information including how to control their blood sugar; tips for talking to the doctor; routine diabetes screening tests; their role in preventing complications; blood sugar testing and supplies; and self-management during an illness. Members are eligible to attend community-based diabetes education classes. Higher risk Members are referred to one-on-one intensive education, which provides education on the importance of regular checkups; checking blood sugars at home; exercising regularly; following a meal plan; taking necessary medication; maintaining recommended weight; taking care of skin and feet; and management of their diabetes in conjunction with other current acute or chronic conditions. Because depression is a well-documented component of this chronic condition, potential behavioral health needs are taken into consideration and incorporated into the plan of care.

2. Asthma Matters: Asthma Management Program

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

The **Asthma Matters** program targets Members identified to have asthma via pharmacy management records, claim and encounter utilization data, and information received via the completion of Member health surveys. Routinely, utilization patterns are assessed, and targeted interventions are implemented to coordinate health care delivery and measures to improve Members' clinical, quality of life, and economic status. Clinical outcomes may include a decrease in the use of beta-agonists, an increase in use of asthma-controlling medications, and an increase in the number of outpatient visits. Improvement in quality-of-life factors may include increased productivity and activity without asthma episodes; decreased absences from work or school; sleeping through the night without asthma episodes; increased knowledge about the disease; and overall asthma control with a decrease in acute asthma episodes. Economic outcome measures include decreased hospital admissions and emergency room events and/or unscheduled

visits.

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

Low Risk	Send education literature bimonthly
Moderate Risk	Send education literature quarterly Provide an age-appropriate peak flow meter and OptiChamber kit Follow-up call/recommend asthma class
High Risk	Send education literature quarterly Provide and age-appropriate peak flow meter, OptiChamber kit, and allergy-free pillow cover Refer to Care Management for further evaluation Possible health assessment and education

Asthma education is coordinated with existing community education programs to promote utilization of services currently available. Members who are categorized in the moderate risk category are mailed a roster of up-to-date classes available in the community. Follow-up calls are conducted for Members who continue to accrue potentially preventable utilization of the emergency room and/or hospitalization, to assess for possible barriers to care and compliance.

Members who require intensive assessment and education are referred to asthma disease management education. Education is provided on an individualized basis, over several visits, to promote Member control and knowledge about their disease. The home environment is assessed, and recommendations are given to decrease the risk of an acute asthma episode.

Our goal is to provide programs, which encourage our Members to actively participate in their asthma management, in collaboration with their physician. As part of the initiative, the PCP receives a copy of the Members' health assessment tool, with a summary of the assigned risk status and educational outreach Community First has

initiated for each Member. Information regarding home assessment and education is also sent to the PCP for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data receive utilization and pharmacy profiles for inclusion in Member's medical record.

3. Healthy Expectations Maternity Program

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

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

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

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

- Completion of a prenatal health risk assessment
- Referral to educational or community resources, as needed
- Education regarding the importance of early prenatal care
- Assignment of a pediatrician prior to birth and newborn checkups
- Education regarding the importance of the 6-week postpartum visit

An assessment program for identified pregnant women provides an opportunity to identify risk factors. Social and behavioral health education and referral are typical

outcome strategies at the initial assessment phase. When completed, the risk tool allows staff time to reach out to those at increased risk for complications. Those at lower risk are sent educational materials and encouraged to attend community sponsored prenatal education classes. Pregnant Members who elect to enroll into the program are routinely reassessed at 20-24 weeks gestation to evaluate for changes in prenatal health.

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

4. Healthy Mind: Behavioral Health Program

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

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

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

Healthy Minds was designed to improve Members' adherence to their physicians' treatment plans by addressing underlying behavioral concerns and facilitating life behavior changes to better manage medical health. Goals include:

- Empowering Members to manage their behavioral symptoms.
- Guiding Members in identifying sustainable solutions to their symptoms.

- Educating Members about their illness(es) and effective treatments.
- Connecting Members with other available care management benefiting Providers to foster continued improvement.
- Advocating for each Member's needs and goals by understanding and respecting the Member's value system while searching for necessary funding, appropriate treatment, and treatment alternatives.
- Integrating medical and behavioral components of treatment to produce long-lasting results.

Healthy Minds was also designed to facilitate continuity and coordination of care among physicians and other health care providers by collecting data on the following:

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

5. Healthy Living: Healthy Lifestyle Management Program

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

The 2019 Bexar County Community Health Assessment Report reflected:

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

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

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

4. Healthy Heart: Blood Pressure Management Program

Community First's **Healthy Heart: Blood Pressure Management Program** is designed to promote effective management of hypertension through the provision of disease management education and care management assistance. The program enables Members diagnosed with the chronic disease to maintain their health and optimally manage their chronic disease condition by preventing health problems, protecting from health threats, and promoting health of self and others.

According to the City of San Antonio's Metropolitan Health District's Mortality in Bexar County 2017 report, chronic diseases were responsible for 6 out of every 10 deaths in Bexar County. Hypertension is a common chronic health condition that can cause catastrophic harm to a patient's body, leading to potential disability, diminished quality of life, stroke, heart attack, heart failure, and kidney disease. There are many risk factors associated with high blood pressure to include age, family history, race, ethnicity, sex, and an unhealthy lifestyle.

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

- Supports the physician/patient relationship and plan of care.
- Emphasizes prevention of exacerbations and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies, such as disease self-management.
- Meets the needs of individuals with specific chronic conditions.

- Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

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

SECTION II
CHIP PERINATE PROGRAM

- Information found in this section (Section II of this Provider Manual) applies to the CHIP Perinate Program only.
- Please refer to Section I for information applicable to the CHIP and CHIP Perinate Newborn Programs only.
- Please refer to Section III for requirements and information applicable to all CHIP programs.

II. CHIP PERINATE PROGRAM FOR PREGNANT WOMEN

A. Introduction

1. Background and Objectives of Program

Welcome to the Community First Health Plans, Inc. Children's Health Insurance Program (CHIP Perinate) Perinatal Network.

The CHIP Perinate Perinatal Program provides services to unborn children of non-Medicaid eligible women. Unborn children will be eligible from conception and, once enrolled, they will receive 12 months of continuous eligibility. Our objective is to ensure that CHIP Perinate Members access prenatal care services appropriately and receive services in the most cost-effective setting. Our network comprises physicians, allied and ancillary health care providers, hospitals and other facilities selected to provide quality health care to our CHIP Perinate and Perinate Newborn Members.

This Manual was designed to assist you and your staff in working with us to deliver quality health care to Community First CHIP Perinate Members.

2. Important Changes in Application Process for Emergency Medicaid

The Texas Health and Human Services Commission (HHSC) is changing the process many expectant mothers use to get perinatal services provided through CHIP. The change involves the form that must be filled out to ensure the hospital is paid labor and delivery facility fees for women with CHIP perinatal coverage whose income is at or below the Medicaid Eligibility Threshold of the Federal Poverty Level.

CHIP perinatal newborn coverage starts the first month the unborn child is determined eligible and lasts for 12 months.

Currently, women in this income range must fill out an application for Emergency Medicaid to cover their hospital labor with delivery fees. This can cause a problem for the hospital if the mother has new income that puts her over the Medicaid limit. The expectant mother will receive this form along with her CHIP perinatal enrollment packet. HHSC will send another copy of the form a month before the baby's due date in

a mailing that includes the letter to remind the expectant mother to send HHSC information about the birth of her child. The woman will be instructed to take Form H3038 to her Provider, to fill out the form, and then mail the form back to HHSC in a pre-addressed, postage-paid envelope. In most cases this activity will happen after delivery when the mother is being discharged from the hospital.

Key Points

- An application process involving filling out an application, providing supporting documentation, and possibly having the applicant attend an interview is still required for:
  - Mothers who do not receive CHIP Perinatal.
  - Mothers receiving CHIP Perinatal who need coverage for a condition not related to labor and delivery.
  - Persons with any other emergency Medicaid need.
- The application process change affects **only** CHIP Perinatal mothers at or below the Medicaid Eligibility Threshold of the Federal Poverty Level having labor and delivery charges. This is a subset of the TP30 population.
- Hospital staff continues to assist CHIP Perinatal mothers with Emergency Medicaid coverage by ensuring moms obtain a properly completed **Form H3038, Emergency Medical Services Certification (Exhibit 27)** from the Provider.

3. Role of CHIP Perinatal Provider

The CHIP Perinatal Provider will provide prenatal care to a pregnant woman during gestation or at delivery to provide the woman with information on immunizations, newborn screenings, postpartum depression, and shaken baby syndrome. The Perinatal Provider will conduct nutritional risk assessments and make referrals when needed; schedule participants for nutritional counseling as needed; and provide nutritional counseling.

Network Limitations

A CHIP Perinate Member may select an OB/GYN who is part of a Limited Provider Network (pregnancy care services).

4. Role of Pharmacy and Pharmacy Provider

The pharmacy is responsible for providing pharmaceutical services to Community First CHIP Perinate Members. The pharmacy provider must verify the eligibility of the Member prior to rendering services. Pharmacy providers are responsible for:

- Adhering to the Formulary and Preferred Drug List (PDL).
- Coordinating with the prescribing physician.
- Ensuring Members receive all medications for which they are eligible.

B. CHIP Perinate Covered Services

NOTE: Inpatient and outpatient behavioral health benefits are not covered benefits for CHIP Perinate Members. Emergency covered services for CHIP Perinate Members are limited to those emergency services that are directly related to the delivery of the unborn child until birth.

CHIP Perinate helps uninsured pregnant women get the services they need, including:

- Prenatal visits
- Prescriptions
- Prenatal vitamins
- Labor and delivery
- Two postpartum checkups

1. CHIP Perinate Schedule of Benefits

COVERED SERVICE	LIMITATIONS
Inpatient General Acute	For CHIP Perinates in families with incomes at or below the Medicaid

COVERED SERVICE	LIMITATIONS
Services include: Covered medically necessary hospital-provided services Operating, recovery, and other treatment rooms Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include but are not limited to dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	Eligibility Threshold of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes above the Medicaid Eligibility Threshold up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery). Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.
Comprehensive Outpatient Hospital, Clinic (including Health Center), and Ambulatory Health Care Center	**May require prior authorization** and physician prescription. Laboratory and radiological services

COVERED SERVICE	LIMITATIONS
Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include but are not limited to dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Cordocentesis are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis,

COVERED SERVICE	LIMITATIONS
	hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
Comprehensive Outpatient Hospital, Clinic (including Health Center) and Ambulatory Health Care Center	Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.
Physician/Physician Extender Professional Services Services include, but are not limited to the following: • Medically necessary physician services (limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth) • Physician office visits, in-patient, and out-	**May require authorization** for specialty services. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal

COVERED SERVICE	LIMITATIONS

patient services
• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
• Medically necessary medications, biologicals, and materials administered in physician's office
• Professional component (in/outpatient) of surgical services, including:
  o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.
  o Administration of anesthesia by physician (other than surgeon) or CRNA
  o Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.
  o Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).
• Hospital-based physician services (including physician-performed technical and interpretive components)
• Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional
	Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.

COVERED SERVICE	LIMITATIONS
services associated with miscarriage or non-viable pregnancy include but are not limited to dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk

COVERED SERVICE	LIMITATIONS
	prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • Laboratory tests (urinalysis for protein and glucose every visit • Hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy • Multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy • Repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated

COVERED SERVICE	LIMITATIONS
	• Screen for gestational diabetes at 24-28 weeks of pregnancy • Other lab tests as indicated by medical condition of client
Prenatal Care and Pre-Pregnancy Family Services and Supplies Covered services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary.	**Does not require prior authorization.** Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status); physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen

COVERED SERVICE	LIMITATIONS
	for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. Emergency services based on prudent layperson definition of emergency health condition. Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. Stabilization services related to the labor and delivery of the covered unborn child. Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

COVERED SERVICE	LIMITATIONS
Case Management Services Case management services are a covered benefit for the unborn child.	These covered services include outreach informing, case management, care coordination and community referral.
Care Coordination Services Care coordination services are a covered benefit for the unborn child.	
Drug Benefits Services include, but are not limited to the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting	Services must be medically necessary for the unborn child.

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage and Billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage and Billing
			newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the

pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

2. Exclusions from Covered Services for CHIP Perinates (Unborn)

For CHIP Perinate families with incomes at or below the Medicaid Eligibility Threshold of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth.

The following inpatient and outpatient treatments (other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth) are excluded from covered services for CHIP Perinates:

- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.

- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post-partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (IRO).
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by Community First except for emergency

care related to the labor with delivery of the covered unborn child.

- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (Care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.
- Coverage while traveling outside of the United States and U.S. territories

(including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam and American Samoa).

3. CHIP Perinate Extra Benefits (Value-Added Services)

CHIP Perinate Value-Added Services	Limits and Restrictions
Baby car seat or safe sleep play yard	Offered to CHIP Members until they are placed in Medicaid or for members who are not Medicaid eligible. Limited to pregnant Members. Upon completion of Healthy Expectations Maternity Program Mommy & Me Baby Shower.
24-Hour Nurse Advice Line	None
Prenatal services with up to $120 in gift cards	Offered to CHIP members until they are placed in Medicaid or for members who are not Medicaid eligible. Limited to pregnant Members. Upon Member's enrollment in Healthy Expectations Maternity Program and agreement to receive Healthy Baby texts ($20); Healthy Expectations baby shower attendance ($10); attendance of first prenatal visit in first trimester or within 42 days of enrolling in the health plan ($20); receipt of the flu shot ($20); attendance of postpartum visit 7-84 days after delivery ($20). Member may be eligible to receive an additional $30 gift card reimbursement upon attendance of a birthing class or towards pregnancy pillow. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.
Low-cost dental services	For Members ages 21 and up and their family members without dental coverage.
Healthy Expectations Maternity	Limited to pregnant Members. Offered to CHIP Members until they are placed in Medicaid or for

CHIP Perinate Value-Added Services	Limits and Restrictions
Program	Members who are not Medicaid eligible.
Mommy & Me Baby Shower	Limited to one baby shower per pregnancy, one diaper bag, and one gift card per Member. Baby shower must be hosted during Member's pregnancy. Limitation does not include mothers expecting multiples. Free gifts for fathers who attend baby shower with mom.
Up to $30 reimbursement for birthing classes or pregnancy item (i.e., pregnancy pillow)	Birthing class must be through the hospital where the Member will deliver their baby.
Transportation assistance to medical and behavioral visits, Community First-sponsored events, health classes, and to attend Member Advisory Group meetings	Children under the age of 18 must be accompanied by a parent or guardian. Assistance available only when the state Medical Transportation Program is not available. The service is available only for established bus service routes, which are exclusive to San Antonio and routes are predetermined by VIA Metropolitan Transit.
Home visits	Home visits for CHIP Perinate high-risk Members including pregnant women, Members with asthma, diabetes, and behavioral health-related conditions. Home visits are contingent upon medical necessity determinations and vary from Member to Member
Gift program and assistance for Members with diabetes	Up to $50 in gift cards for members enrolled in Diabetes in Control: Diabetes Management Program. $20 gift card for enrolling in the program; $10 gift card for participation in the educational sessions; $10 gift card for receiving a dilated eye exam; $10 gift card for receiving an A1c screening. Gift card restrictions include no beer, wine, alcohol, cigarettes, or OTC drugs may be purchased.

CHIP Perinate Value-Added Services	Limits and Restrictions
Gift program and assistance for Members with asthma	Up to $10 in gift cards are available for health-related items for Members with asthma after completion of asthma education. Members must be enrolled in Asthma Matters: Asthma Management Program. Gift card restrictions include no beer, wine, alcohol, cigarettes, or OTC drugs may be purchased.
Online mental health resources	None
Prescription Savings Card approved for use by uninsured family members	None
Smart phone with up to 500 minutes including unlimited texting and 4.5 GB of data	Limited to one per household.

Durable Medical Equipment (DME)

DME is not a covered benefit for CHIP Perinate Members.

C. Coordination with Non-CHIP Perinate Covered Services (Non-Capitated Services)

Community First collaborates and coordinates with Texas Agency Administered Programs, case management services and Essential Public Health Services for CHIP Perinate Members, including:

- Case Management for Children and Pregnant Women (CPW)
- Women, Infants and Children (WIC)
    - Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin

- Vendor Drug Program

1. Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) is a case management program that provides health-related case management services to eligible children and pregnant women.

CPW Eligibility

Any CHIP eligible pregnant woman (of any age) or child (birth through age 20) with a health condition or health risk is eligible for the CPW program. Health condition or health risk is defined as a medical condition, illness, injury, or disability that results in limitation of function, activities or social roles in comparison with same age peers in the general areas of physical, cognitive, emotional or social growth, and development. There must also be a need for services to prevent illness(es) or medical condition(s), to maintain function or to slow further deterioration of the condition and desire health related case management services or a pregnant woman with a high-risk condition during pregnancy.

CPW case managers must provide services directly with the client or with the parent/legal guardian if the client is under the age of 18. Requests for CPW services may be initiated by the Provider, the Member, or a family member.

CPW case managers submit requests to the Department of State Health Services for determination of eligibility for case management services. Licensed social workers and Registered Nurses provide CPW services.

To make a referral, call a CPW case management provider in your area. A list of CPW providers can be found on the DSHS Case Management Website.

Women, Infants, and Children Program (WIC)

WIC is a nutrition program that helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy. Nutrition education and counseling, nutritious foods, and help accessing health care are provided to low-income women, infants, and children through the Special Supplemental Nutrition Program, popularly known as WIC.

Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. Please visit https://texaswic.org/ for more details.

WIC Eligibility

- **Meet the income guidelines.** Households with incomes at or below the Medicaid Eligibility Threshold of the Federal Poverty Level are eligible according to the Texas WIC Income Guidelines. WIC determines income based on gross income. WIC counts all of the Members of a household, related, or unrelated. WIC counts an unborn baby as a household Member.
- **Be at nutritional risk.** WIC clients receive an initial health and diet screening at a WIC clinic to determine nutritional risk. WIC uses two main categories of nutritional risk: (1) medically based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and (2) diet-based risks such as poor eating habits that can lead to poor nutritional and health status. Clients will be counseled at WIC about these risks and the outcome influenced by nutrition education and nutritious foods provided by WIC.
- **Live in Texas.** WIC clients usually receive services in the county where they live. U.S. citizenship is not a requirement for eligibility.
- Clients must apply **in person** except in certain limited cases.

All WIC services are free to those who are eligible.

WIC provides benefits each month which are taken to grocery stores and used to buy nutritious foods. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C–rich fruit and vegetable juice, milk, eggs, cheese, beans, and peanut butter. Different food packages are issued to different clients. For example, mothers who are totally breastfeeding their babies without formula are issued tuna and carrots in addition to other foods.

Clients receive encouragement and instruction in breastfeeding. In many cases, breastfeeding women are provided breast pumps free of charge. WIC helps clients learn why breastfeeding is best for their baby, how to breastfeed while still working,

For information on how to apply for WIC, call **1-800-942-3678**.

D. OB/GYN Responsibilities

1. Access to OB/GYNs

Network OB/GYNs must be accessible to CHIP Perinate Members 24 hours a day, 7 days a week, or make other arrangements for the provision of services. The following are examples of acceptable and unacceptable phone arrangements for network OB/GYN after normal business hours.

Acceptable Access

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

Unacceptable Access

- The office phone is only answered during office-hours.
- The office phone is answered after-hours by a recording, which tells patients to leave a message.
- The office phone is answered after-hours by a recording which directs patients to go to an emergency room for any services needed.

2. Availability Standards for OB/GYNs

TYPE OF APPOINTMENT	APPOINTMENT AVAILABILITY
Emergency Care	24 hours a day, 7 days a week, upon Member presentation at the delivery site, including non-network and out-of-area facilities
Urgent Care	Within 24 hours of request
Prenatal Care (Initial)	14 calendar days or less or by the 12th week of gestation. Members who express concern about termination will be addressed as urgent care.
High-risk pregnancies or new Members in the third trimester	Within 5 days or immediately if an emergency exists.
Radiology Urgent MRI/CT Scan IVP/UGI Mammogram	 Within 24 hours 7 days or less 10 days or less 21 days or less
Provider office waiting time	Within 30 minutes of scheduled appointment time.
Requests for feedback from pharmacy related to prescriptions	Within 24 business hours

Verifying Member Eligibility and Benefits

OB/GYNs should always verify the eligibility of the CHIP Perinate Member prior to rendering services by calling Community First Member Services at **(210) 358-6300** during office hours or by logging into the Provider Portal.

3. Member's Right to Designate an OB/GYN

Community First **does not** limit the selection of an OB/GYN to the PCP's network.

ATTENTION FEMALE MEMBERS

You have the right to select an OB/GYN without a referral from your PCP. The access to health care services of an OB/GYN includes:

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

E. Pregnancy Verification Requirements for CHIP Perinate

Applicants

New Policy: The following are acceptable forms of pregnancy verification for determining eligibility for the Medicaid for Pregnant Women, CHIP, and CHIP Perinatal Program.

1. Form H3037, Report of Pregnancy or

2. Any written document containing the same information as Form H3037, including:
   a. Pregnant woman's name
   b. Case name (or head of household, if different)
   c. Month pregnancy began
   d. Number of births expected
   e. Anticipated date of delivery
   f. Signature of physician, nurse, advanced nurse practitioner, or other medical professional (under physicians' orders)

CHIP Perinate applicants will be required to submit verification of pregnancy with the application. If the verification is not submitted with the application, applications will be pended for missing information.

If a CHIP Perinatal application is determined to have missing information, the applicant is notified of the missing information in writing. The applicant has 15 business days to provide the missing information, or the application is timed out. If the applicant provides the missing information by the 60th day from the application file date, the application will be reopened using the date the missing information is provided as the new file date. If the applicant provides the missing information after the 60th day, the applicant must reapply.

F. Member Eligibility

1. Member Eligibility

Each CHIP Perinate Program Member is issued a **CHIP Perinate Member ID Card (Exhibit 3c)** and is instructed to present the card when requesting medical services. The CHIP Perinate Member ID card indicates pertinent CHIP Perinate Member information, OB/GYN name and telephone number, and Community First telephone numbers.

At the time of the visit, the Member must show their Community First CHIP Perinate ID card, or in some instances, the CHIP Perinate Enrollment form (for the first 30 days after enrollment). The Community First CHIP Perinate ID card, however, does not guarantee eligibility for coverage.

2. Pregnancy and CHIP Perinate Eligibility

CHIP Perinate Members

CHIP Perinate Members should contact Community First Member Services as soon as the Member is eligible with Community First. Providers are required to contact Community First when a pregnant CHIP Perinate Member is identified.

CHIP Perinate Newborns

Community First is responsible for all covered services related to the care of a newborn child from the date of birth, if the mother is enrolled with the Community First CHIP Perinate Program at the time of birth.

3. Span of Eligibility

Community First will arrange for all covered services for the period that CHIP Perinate Members are eligible. CHIP Perinate Members have eligibility for 12 months. Determination of eligibility is assumed by HHSC.

4. CHIP Perinate Member Plan Changes

a. A CHIP Perinate (unborn child) who lives in a family with an income at or below the Medicaid Eligibility Threshold of the Federal Poverty Level (FPL) will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

b. A CHIP Perinate mother in a family with an income at or below the Medicaid Eligibility Threshold of FPL maybe eligible to have the cost of the birth covered through Emergency Medicaid. Clients under the Medicaid Eligibility Threshold of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.

c. A CHIP Perinate will continue to receive coverage through the CHIP program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid Eligibility Threshold of the FPL to 200% FPL and the birth is reported to HHSC's enrollment broker.

d. A CHIP Perinate Newborn is eligible for 12 months' continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal Health Plan.

e. CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to

select another MCO.

f. When a Member of the household enrolls in a CHIP Perinatal Program, all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if the plan is different. All Members of household must remain in the same health plan until the latter of:

- The end of the CHIP Perinate Member's enrollment period.
- The end of the traditional CHIP Member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her sibling's existing CHIP case.

g. CHIP Perinatal Members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in the CHIP Perinatal Program.
- If the Member moves into a different delivery area.
- For cause at any time.
- During the annual re-enrollment period.

5. Involuntary Disenrollment

CHIP Perinate Members can be disenrolled for any of the following reasons:

- Change in health insurance status, such as enrolling in an employer-sponsored health plan.
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP/CHIP Perinatal.
- Immigration.
- Increased income.

- Provisional eligibility term.
- Health plan change.
- No longer CHIP/CHIP Perinatal-eligible.

Community First has the limited right to request disenrollment of CHIP Perinate Members from our health plan. HHSC will make the final decision on any request by Community First for such disenrollment.

The CHIP Perinate Member may request the right to appeal such decision. The OB/GYN will be responsible for directing the Member's care until the disenrollment is made.

Request to disenroll a Community First CHIP Perinate Member is acceptable under the following circumstances:

- The Member misuses or lends his/her Community First Membership ID Card to another person to obtain services.
- The Member is disruptive, unruly, threatening, or uncooperative to the extent that the CHIP Perinate Member seriously impairs Community First's or a Provider's ability to provide services to the Member. This only occurs, however, if the Member's behavior is not due to a physical or behavioral health condition.
- The CHIP Perinate Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First to arrange for the treatment of the condition.
- The Member's disenrollment request from managed care will require medical documentation from the OB/GYN or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

The Provider cannot take retaliatory action against Member.

G. CHIP Perinate Member Rights and Responsibilities

Member Rights

a. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.

b. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.

c. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

d. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.

e. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.

f. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.

g. You have the right and responsibility to take part in all the choices about your unborn child's health care.

h. You have the right to speak for your unborn child in all treatment choices.

i. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.

j. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.

k. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a

right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

l. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

a. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.

b. You must become involved in the doctor's decisions about your unborn child's care.

c. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.

d. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.

e. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

f. You must report misuse of CHIP Perinatal services by health care providers, other Members, or health plans.

g. Talk to your provider about all of your medications.

H. Healthy Expectations Maternity Program

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

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

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

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

- Completion of a prenatal health risk assessment.
- Referral to educational or community resources, as needed.
- Education regarding the importance of early prenatal care.
- Assignment of a pediatrician prior to birth and newborn checkups.
- Education regarding the importance of the 6-week postpartum visit.

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

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

SECTION II
ALL CHIP PROGRAMS

- Information found in this section (Section III of this Provider Manual) applies to all CHIP programs.
- Please refer to Section I for information applicable to the CHIP and CHIP Perinate Newborn Programs only.
- Please refer to Section II for requirements and information applicable to the CHIP Perinate Program only.

III. REQUIREMENTS & INFORMATION COMMON TO ALL CHIP PROGRAMS

A. Legal and Regulatory

1. Law, Rules, and Regulations

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

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

Environmental Protection Laws

- Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

- National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514, "Protection and Enhancement of Environmental Quality," relating to the institution of environmental quality control measures.

- Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to federal Contracts, Grants, and Loans").

- State Clean Air Implementation Plan (42U.S.C. §740 et seq.) regarding conformity of federal actions to state Implementation Plans under §176(c) of the Clean Air Act.

- Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water.

State and Federal Anti-Discrimination Laws

- Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15.

- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.).

- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107).

- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688).

- Food Stamp Act of 1977 (7 U.S.C. §200 et seq.).

- Executive Order 13279, and its implementing rules for equal protection of the laws for faith-based organizations.

2. Liability

In the event Community First becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against Community First will be through Community First's bankruptcy, conservatorship, or receivership estate.

The Provider understands and agrees that Community First Members may not be held liable for Community First's debts in the event of Community First's insolvency.

The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, Community First, its employees, agents or subhealth plans. Further,

the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by Community First or any judgment rendered against Community First. HHSC's liability to the Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

3. Medical Consent Requirements

Providers must comply with medical consent requirements in Texas Family Code §266.004, which require the Member's Medical Consenter to consent to the provision of medical care. Providers must notify the Medical Consenter about the provision of Emergency Services no later than the second business day after providing Emergency Services, as required by Texas Family Code §266.009.

4. Member Communication

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

5. Fraud, Waste, and Abuse

Fraud Information

Reporting Waste, Abuse, or Fraud by a Provider or Client

Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/
    - Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

  Community First Health Plans
  12238 Silicon Drive, Suite 100
  San Antonio, TX 78249
  Phone: **1-800-434-2347**

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
    - Name, address, and phone number of provider
    - Name and address of the facility (hospital, nursing home, home health agency, etc.)
    - Medicaid number of the provider and facility, if you have it
    - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
    - Names and phone numbers of other witnesses who can help in the investigation
    - Dates of events
    - Summary of what happened

- When reporting about someone who gets benefits, include:
    - The person's name
    - The person's date of birth, Social Security number, or case number if you have it
    - The city where the person lives
    - Specific details about the waste, abuse, or fraud

If the Provider receives annual CHIP payments of at least $5 million (cumulative, from all sources), the Provider must:

1. Establish written policies for all employees, managers, officers, health plans, subhealth plans, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.
2. Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

Providers Under Investigation

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

6. Reporting Abuse, Neglect, and Exploitation

Report Suspected Abuse, Neglect, and Exploitation (ANE)

Community First Health Plans must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include Community First and Provider responsibilities related to identification and reporting of ANE. Additional state laws related to Community First and Provider requirements continue to apply.

The Provider must provide Community First with a copy of the ANE report findings within one (1) business day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the Provider is responsible for reporting individual remediation on confirmed allegations to Community First.

The Provider may be required to complete the mandatory challenge survey.

Report to HHSC if the victim is a child/youth who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs)

Providers are required to report allegations of ANE to both DFPS and HHSC, as is Community First. Contact HHSC at **1-800-458-9858**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- A child/youth with a disability or child residing in or receiving services from one of the following providers or their health plans:
    - Local Intellectual and Developmental Disability Authority (LIDDA)
    - Local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid managed care organization to provide behavioral health services
- A managed care organization
- An officer, employee, agent, health plan, or subhealth plan of a person or entity listed above
- An adult or child/youth with a disability receiving services through the Consumer Directed Services option

Contact DFPS at **1-800-252-5400** or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement

If a Provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family Member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

7. Insurance

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

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

8. Marketing

The Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual.

The Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

9. Provider Network Requirements

Under CHIP agreements, the TPI and NPI for Acute Care Providers serving CHIP Members must enter into and maintain a CHIP Provider agreement with HHSC or its agent to participate in the CHIP Program and must have a Texas Provider Identification Number (TPIN). All CHIP Providers, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

10. Non-Discrimination by Participating Provider

According to your contract with Community First, you as a participating Provider agree to comply with the following requirements:

- Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the American with Disabilities Act of 1990, and all the requirements set forth by the regulations in carrying out these acts and all amendments to the laws and regulations.
- Medical records comply with Texas Health and Safety Code Section 85.113 (relates to workplace and confidentiality guidelines regarding AIDS and HIV).
- Regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973.

11. Medical Records Documentation Guidelines

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled in a confidential manner and organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries, and other pertinent medical information are readily accessible, and that the events are documented clearly and completely. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

Community First follows guidance from the Centers for Medicare and CHIP regarding 1997 CMS documentation and coding guidelines, the National Correct Coding Initiative, Global Surgical Period, and Physician Signature Guidelines in addition to current American Medical Association (AMA) Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10). The Texas CHIP Provider Procedures Manual also recognizes guidelines from the Centers for Medicare and CHIP regarding medical record documentation standards for coding and billing.

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) and the International Classification of Diseases, 9th Revision Clinical Modification (ICD-10 CM) systems be used to report professional services, including physician services and diagnoses. Correct use of CPT and ICD-10 coding requires using the most specific code that matches the services provided and illnesses based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

Amendment to Medical Records

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

- The Provider must have specific recollection of the services provided which is documented.
- A Provider may add a missing signature without a time restriction if the Provider created the original documentation him/herself.

The above does not restrict or limit the Provider's ability to document or amend medical records at any time to more accurately describe the clinical care provided to the patient. For medical record review/audit and reimbursement purposes, documentation is not considered appropriate and/or timely documented if originally completed after thirty (30) days of the date of service.

Definitions

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

Addendum means the provision of additional information that was not available at the time of the original entry. The addendum should be timely, reflect the current date, Provider signature and the rational for the addition or clarification of being added to the medical record.

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

Medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Medical Record Documentation

Community First requires all Providers to create and keep appropriate medical records in compliance with generally accepted medical records standards. Records

must be maintained for 10 years past the end the contract period (currently 8/31/2013), and all medical records must be kept until all audit questions, appeal hearing, investigations, or court cases are resolved.

The Provider agrees to provide, at no cost to the MCO, records requested for the purpose of HEDIS audits or Special Investigation Unit audits. Upon receipt of the request Provider must provide the records within the time frame and manner listed in the notification of audit.

Failure to supply the requested information may result in recovery of the payment for the services and/or submission to the OIG for failure to supply records.

The Provider agrees to provide, at no cost to HHSC, the following:

1. All information required under Community First managed care contract with HHSC, including, but not limited to, the reporting requirements and other information related to the Provider's performance of its obligations under the contract.
2. Any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.
3. All information in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

Upon receipt of a record review request, a Provider must comply, at no cost to the requesting agency, HHSC, Office of the Inspector General (OIG), or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions. The records must be provided within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, the Provider must provide the records requested at the time of the request and/or in less than 24 hours.

The request for record review includes, but is not limited to, clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items,

equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with Providers and subhealth plans. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the Provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.

The records must reflect all aspects of patient care, including ancillary services. These standards must, at a minimum, include the following documentation requirements:

- **Patient identification information.** Each page or electronic file in the record contains the patient's name and patient ID number.
- **Personal/biographical data**, including age; sex; address; employer; home and work telephone numbers; and marital status.
- **All entries are legible** to individuals other than the author, dated, and signed by the performing Provider.
- **Allergies.** Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
- **Evaluation and Management codes** are supported by the documentation in the clinical record. Providers must follow the most current CMS documentation guidelines when selecting the level of service provided.
- **Immunizations.** For pediatric records there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Medically necessary **diagnostic lab and X-ray results** are included in the medical record and include an explicit plan of care for any abnormal findings.
- Required follow-up visits specify time of return by at least the week or month.
- **Unresolved problems** are noted in the record.
- Member is provided **basic teaching/instructions** regarding physical and/or behavioral health condition.
- **Smoking/Alcohol/Substance Abuse**. Notation concerning cigarettes and alcohol

use and substance abuse is present. Abbreviations and symbols may be appropriate.

- **Consultation, Referrals and Specialist Reports**. Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- **All emergency care provided** (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
- **Hospital Discharge Summaries**. Discharge summaries are included as part of the medical record for: (1) all hospital admissions, which occur while the patient is enrolled with the health plan, and (2) prior admissions as necessary. Pertaining to admissions, which may have occurred prior to Member being enrolled with the health plan and are pertinent to the Member's current medical condition.
- **Advance Directive**. For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- Providers are required to submit information for **the Health Passport.**
- **Evidence and results of medical, preventive, and behavioral health screening.**
- **All treatment provided** and results of such treatment.
- **The team Members involved** in the multidisciplinary team of a Member needing specialty care.
- **Integration of clinical care** in both the physical and behavioral health records.
- **Screening for behavioral health conditions** (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated.
- **Screening and referral by behavioral health providers** to PCPs when appropriate.

- **Receipt of behavioral health referrals** from physical medicine providers and the disposition/outcome of those referrals.
- At least quarterly (or more often if clinically indicated), **a summary of status/progress from the behavioral health** provider to the PCP.
- **A written release of information,** which will permit specific information-sharing between Providers.
- **That behavioral health professionals are included** in primary and specialty care service teams described in the contract when a Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Release of Information

Providers should obtain from CHIP Members a signed authorization for release of information. The Provider may use the standard CMS 1500/UB04 or develop his/her own form. If developing his/her own form, the release should allow the Provider to disclose information to Community First and DSHS. This will enable Community First to process claims and perform utilization management and quality management functions.

12. Credentialing and Recredentialing

All applicants for participation undergo a careful review of their qualifications, including education, training, licensure status, board certification, hospital privileges, and work and malpractice history. Providers who meet the criteria and standards of Community First are presented to the Credentials Committee for final approval of their credentials.

Re-credentialing is performed at least every three (3) years. In addition to the verification of current license, DEA, malpractice insurance, National Practitioner Data Bank query and current hospital privileges, the process may also include

- Member survey results
- Complaints and Grievances

- Utilization data
- Compliance of Community First policies and procedures
- An office site review and evaluation
- A medical record audit

Advance Nurse Practitioner Requirements

To be a Provider of CHIP covered services, an Advance Nurse Practitioner must:

- Be licensed by the Texas State Board of Nurse Examiners
- Be licensed by the licensing authority as an Advance Nurse Practitioner
- Comply with all applicable federal and state Laws and regulations governing the services provided
- Be enrolled and approved for participation in the Texas Medical Assistance Program
- Sign a written provider agreement with the department or its designee
- Comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards and guidelines published by the department or its designee
- Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the department or its designee

Advance Nurse Practitioner Benefits and Limitations

Subject to the specifications, conditions, requirements and limitations established by the department or its designee, services performed by Advance Nurse Practitioners are covered if the services:

- Are within the scope of practice for Advance Nurse Practitioners, as defined by state law
- Are consistent with rules and regulations promulgated by the Texas State Board of

Nurse Examiners or other appropriate states licensing authority

- Would be covered by the Texas Medical Assistance Program if provided by a licensed physician (MD or DO)

To be payable, services must be reasonable and medically necessary as determined by the department or its designee.

Advance Nurse Practitioners who are employed or remunerated by a physician, hospital, facility or other provider must not bill the Texas Medical Assistance Program directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital or other provider (if the provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses Advance Nurse Practitioners. The basis and amount of CHIP reimbursement depend on the services actually provided, who provided the services and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the providers involved.

The policies and procedures in this subchapter do not apply to certified registered nurse anesthetists and certified nurse-midwives. Coverage of services provided by certified nurse-midwives and certified registered nurse anesthetists are described in subchapters Q and V of this chapter (relating to Nurse-Midwife Services and Certified Registered Nurse Anesthetists Services).

On-Site Reviews

As part of its QIP, Community First conducts periodic facility and medical record audits for PCPs who have 50 or more Community First Members, and to research cases of potential quality issue. The reviews are used in the re-credentialing process, to substantiate the quality of the services provided to health plan Members, to augment and improve Healthcare Effectiveness Data and Information Set (HEDIS) quality data, and to confirm the services billed to Community First. Record reviews are considered an essential method of identifying potential quality of care issues and opportunities for Practice Guideline development.

Community First adopted medical record standards that assist with evaluating patient care to ensure conformance with Quality-of-Care Standards. Providers must conform to the standards to remain a network Provider. Providers will be evaluated at least every

three years and will be notified of the scheduled audit by the Quality Management Department prior to the review. The audit routinely consists of three components:

- Documentation
- Continuity of Care
- Preventive Care

A copy of the **Medical Record Review Tool (Exhibit 12)** and the **CDC Vaccine Information for Adults (Exhibit 14)** are enclosed in this manual for your review. You will receive written feedback on the results of the record review along with any recommendations regarding documentation. Those areas with scores below the established benchmarks will be required to adopt a Corrective Action Plan. The Community First Quality Management Department may provide educational assistance with medical record documentation, if desired. Repeat audits are performed if problems are identified. Results of medical record audits are trended and reported to the Quality Improvement Committee to identify areas needing improvement or follow-up action needed based on peer review guidance.

13. Updates to Contact Information

Providers must inform both Community First and HHSC's administrative services contractor of any changes in the Provider's address, telephone number, group affiliation, etc.

14. Mandatory Challenge Survey

Community First is required to develop and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. Community First must design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing Community First's Provider Portal functionalities. At a minimum, the challenge survey will include verification of the following elements:

1. Provider Name
2. Address
3. Phone Number
4. Office Hours

5. Days of Operation
6. Practice Limitations
7. Languages Spoken
8. Provider Type / Provider Specialty
9. Pediatric Services
10. Wait Times for Appointment as defined in Section 8.1.3.1
11. Closed or Open Panel (PCPs only)
12. Well Child Provider (PCP only)

Community First collects, analyzes, and submits survey results as specified in UMCM Chapter 5.4.1.10, "Provider Network Examination."

Community First will enforce access and other network standards required by the contract and take appropriate action with Providers whose performance is determined by Community First to be out of compliance.

15. Confidentiality

Providers must treat all information that is obtained through the performance services included in the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC programs.

The Provider must protect the confidentiality of Member Protected Health Information (PHI), including patient records and electronic medical records (EMR). Providers must comply with all applicable federal and state laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

16. Potentially Preventable Complications (PPC) and Provider Preventable Readmissions (PPR)

Potentially preventable complications are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

The PPC analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Complications in the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC programs.

PPCs are classified into two separate categories:

1. Hospital Acquired Conditions (HAC)
    a. As part of the payment determination, the Centers for Medicare and Medicaid Services (CMS) has designated fourteen (14) categories of hospital acquired conditions (HAC), which are conditions not present on admission (POA) on a UB-04 claim form:

Category 1: Health Care-Acquired Conditions (For Any Inpatient Hospitals Settings in Medicaid)

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma, including Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, Electric Shock
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control, including Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
- Surgical Site Infection Following:
    - Coronary Artery Bypass Graft (CABG) - Mediastinitis
    - Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
    - Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow

- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions

Category 2: Other Provider Preventable Conditions (For Any Health Care Setting)

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
- OPPCs identified in the state's plan and according to the requirements of the final regulation

Potentially preventable readmissions are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. Texas Medicaid uses a 15-day readmission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

PPR Analysis

The PPR analysis is performed in accordance with TAC, §354.1445 Potentially Preventable Readmissions. (Texas Administrative Code Rules)

On an annual basis MCOs and hospitals receive access to their state fiscal year (SFY) PPR and PPC hospital level reports and underlying excel data files. These reports are compiled using claim data from managed care organization inpatient data. The MCO is responsible for configuring their payment systems to ensure these reductions are applied. Community First utilizes the Optum software which is pre-configured with these rate reductions.

B. Quality Improvement Program

Community First's Quality Improvement Plan (QIP) is designed to communicate the overarching organizational work plan to achieve optimal care with emphasis on safety

and service to health plan Members, and to facilitate a culture of continuous improvement. It includes essential information on the structure Community First will operationalize to manage, deploy, and review quality throughout the organization, including a detailed description of the organizational structure, staffing, and the committees required to support Community First quality initiatives and the scope of responsibilities.

The QIP is updated regularly to reflect what Community First is doing to improve quality and is developed as an outgrowth of the evaluation of the previous years' quality improvement activities, organizational priorities, and program requirements. It defines the lines of accountability between the quality improvement program and the Community First Board of Directors.

Committees meet regularly to report findings, recommendations, and resolutions/corrective action plans through the Quality Infrastructure. Operational meetings are held on a routine basis to allow for timely communication throughout the organization. Key areas responsible for the QIP include all areas of the organization, from the President/CEO to every department and committee at Community First.

1. Delegation of QIP Activities

Community First does not delegate any QIP management activities.

Providers who have been delegated activities, such as credentialing and/or utilization review, are required to have quality improvement programs in place, which meet all the requirements of Community First and/or regulators.

As specified in the Administrative Delegated Service Agreement, the Provider must submit routine reports to the Community First's Quality Management Department, or other departments as required, regarding activities, including the results of reviews of potential quality issues and studies. Delegated entities are audited annually for compliance with the Community First QIP. If necessary, quality improvement plans are initiated by Community First with defined outcomes and deadlines.

2. Practice Guideline Development

Community First has established a process for evaluating patterns of care for specific conditions and procedures. Clinical Guidelines, including Pediatric and Adult

Preventive Care guidelines and Disease Management guidelines, have been reviewed and approved by the Quality Improvement Committee.

The Quality Improvement Committee has also approved practice guidelines for both asthma and diabetes. These guidelines will be used to assess the quality of health care delivery for these disease entities. Other practice guidelines may be developed and approved by the Quality Improvement Committee. Compliance with the guidelines is evaluated during clinical and medical record reviews.

The success of the QIP depends upon the Provider's cooperation by:

- Providing medical records concerning Community First CHIP Members upon request.
- Maintaining the confidentiality of CHIP Member information.
- Promptly responding to our phone calls or letters concerning Quality Management issues.
- Cooperating with our Quality Improvement Committee proceedings.
- Participating on our Quality Improvement Committee, Credentialing Committee, or Pharmacy and Therapeutics committees, if appropriate. These committees consist of Providers who are board-certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Provider Relations Representative.

3. Focus Studies and Utilization Management Reporting Requirements

In addition to any focus studies performed on behalf of HHSC, Community First performs focus studies as part of the QMIP to objectively and systematically monitor and evaluate the quality of care and service provided to Community First Members. The studies are performed based on topics and tools agreed upon by the Quality Improvement Committee. Providers are notified of audits (if medical record review is necessary) at least two (2) weeks in advance. Study findings are submitted to Providers, and if indicated, quality improvement plans are initiated by Community First with defined outcomes and deadlines.

The Provider agrees to comply with Community First's program termination requirements. The Provider also understands and agrees that any Provider performance

data gathered by Community First as part of its QIP Program may be published on its website or other such reports, excluding Member-specific data or any Protected Health Information.

4. Office Site Visit/Potential Quality Issues (PQIs)

Community First conducts office site visits to the Provider/practitioner's office to investigate Member complaints/PQIs related to physical accessibility, physical appearance, and adequacy of exam room and waiting room space. Office site visits also can be conducted as part of the credentialing process, or as part of standard audits to ensure standards are being met. Standards are determined based on NCQA guidelines, state and federal regulations.

Site visits conducted by Community First representatives include, at a minimum:

- Staff information
- Access for the disabled
- Licensure
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained
- Cultural competence
- Physical accessibility (access, office hours, wait time, preventive health appointment)
- Physical appearance
- Adequacy of waiting and examining room space
- Scheduling/appointment availability, including office protocols/policies
- Availability of emergency equipment
- Clinical Laboratory Improvement Amendments (CLIA) standards
- Medication administration/dispensing/ storage of drug samples
- Adequacy of medical record-keeping practices

C. Utilization Management

Community First's Utilization Management program determines whether proposed or rendered medical services and/or supplies are medically necessary and appropriate, are of a generally acceptable high quality and appropriate frequency, done in the appropriate setting and covered in the CHIP Member's benefit plan. Program components include preauthorization, concurrent stay review, discharge planning, retrospective review, disease management, and case management.

Providers may initiate prior authorization through the Provider Portal or fax **(210) 358-6040**.

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

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. Community First does not specifically award practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Besides processing requests for authorizations, Utilization Management analyzes utilization patterns, and provides an appeal process to address disputes in a timely manner

All reimbursement is subject to eligibility and contractual provisions and limitations.

"Prior Authorization Not Required" does not mean that service is covered. Please contact Member Services at **(210) 358-6060** should you have questions regarding covered services.

Successful operation of our Utilization Management program depends upon the Provider's cooperation by:

- Accepting and returning our phone calls concerning our CHIP Members

- Providing Community First with complete medical documentation to support any preauthorization requests
- Allowing us to review medical and billing records concerning care rendered to our CHIP Members to validate delivery of care against claims data
- Participating with us in discharge planning, disease management, and case management
- Participating with our Community First's committee proceedings when appropriate

Community First currently requires preauthorization for certain services. Please review the Prior Authorization List for a list of these services.

The list of services requiring preauthorization is subject to change. Community First will provide at least 90 days' notice of changes in the list of authorized services.

D. Provider Complaint and Appeal Process

1. Provider Complaints to Community First

Community First has a process to address Provider complaints in a timely manner, which is consistent for all network Providers. Community First and the Provider have an obligation under their mutual contract provisions to make a good faith effort to resolve any disputes arising under the agreement. In the event a dispute cannot be resolved through informal discussions, the Provider must submit a complaint to Community First which specifically sets forth the basis of the complaint along with a proposed resolution. Providers may submit complaints:

- Orally, by calling **(210) 358-6294** or **1-800-434-2347**
- Online, by emailing ProviderRelations@cfhp.com (via secure/encrypted email)
- Via the Community First secure Provider Portal by clicking the "Contact Us" link
- Via fax to Community First's Provider Relations Department at **210-358-6199**

- Please include fax cover sheet along with **Provider Complaint Form (Exhibit 20)**

Providers should retain the following documentation:

- Fax cover pages
- Emails to and from Community First
- A log of telephone communication

Upon receipt of a written **Provider Complaint Form (Exhibit 20)**, the Provider Relations Department will send a letter acknowledging receipt of the complaint within five (5) working days from the date of receipt.

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

If the Provider and Community First are unable to resolve the complaint, the Provider may submit an appeal, orally or in writing, to Community First. Upon receipt of a written appeal, Community First will send a letter acknowledging the request for an appeal within five (5) working days from the date of receipt.

Community First will then send written notification within thirty (30) calendar days from the receipt of the appeal to the Provider of the acceptance, rejection, or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First's final determination. The notification will advise the Provider of his or her right to submit the complaint to binding arbitration. Any binding arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association unless the Provider and Community First mutually agree to some other binding arbitration procedure.

2. Provider Appeals to Community First

If you wish to appeal a decision made by Community First that the health care services furnished or proposed to be furnished to a CHIP Member are not medically necessary, you or the Member may appeal orally, followed up with a written appeal.

- Members: Orally, by calling **(210) 358-6060** or **1-800-434-2347**
- Providers: Orally, by calling **(210) 358-6294** or **1-800-434-2347**
- Via the Community First secure Provider Portal by clicking the "Contact Us" link
- Via fax to Community First's Provider Relations Department at **210-358-6199**
    - Please include fax cover sheet along with **Provider Complaint Form (Exhibit 20)**

Providers should retain the following documentation:

- Fax cover pages
- Emails to and from Community First
- A log of telephone communication

Provider Appeals Process

a. Within (5) working days from receipt of the appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the appeal. This letter will include a reasonable list of documents that need to be submitted to Community First for the appeal.

b. Emergency care denials, denials for care of life-threatening conditions, and denials of continued stays for hospital patients may follow an expedited appeal procedure. This procedure will include a review by a health care provider who has not previously reviewed the case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one (1) working day following the date that the appeal, including all necessary information to complete the appeal, is made to Community First.

c. After Community First has sought review of the appeal, we will provide written notification to the Member, Member's representative, and the Member's physician or health care provider explaining the resolution of the appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than thirty (30) days after we receive the oral or written request for appeal. The notification will include:

- A clear and concise statement of the specific medical or contractual reason for the resolution
- The clinical basis for such decision
- The specialty of any physician or other provider consultant

If the appeal is denied, the written notification will include notice of the appealing party's right to seek a Member Independent Review Organization (IRO). (See Member Complaints and Appeals section).

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

3. Provider Complaint and Appeal Process to TDI

A Provider, who believes they did not receive full due process from Community First, has the right to file a complaint or an appeal with the Texas Department of Insurance at any time.

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

1-800-252-3439
Fax: **(512) 475-1771**
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

E. Member Complaint/Appeal Process

1. Member Complaints to Community First

CHIP Members may file a complaint with Community First at any time.

A complaint means an expression of dissatisfaction expressed by a complainant, orally or in writing, to Community First about any matter related to the health plan other than an adverse benefit determination. According to 42 C.F.R. § 438.400(b), a grievance may also include an appeal of an adverse determination.

Possible subjects for complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes the Member's right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

If the Member wishes to file a complaint, a Community First Member Services Representative can help. Please direct the Member to call Member Services toll-free at **1-800-434-2347**.

Members may also send written complaints to:

Community First Health Plans
Member Services Department
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Members may contact Community First Member Services to request assistance in filing a complaint. We will mail a letter to the complainant within five (5) days, to inform them that we have received their complaint. Then, we will mail a letter with our decision within 30 days.

If the Member is not satisfied with the outcome of the complaint, the Member may file a complaint with the Texas Department of Insurance (TDI).

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

1-800-252-3439
Fax: **(512) 475-1771**
Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

2. Member Appeals

CHIP/CHIP Perinatal Members may request an appeal if Community First **denies or limits a request for a covered service.** The Member and Provider will receive a letter telling them if a service or medicine has been denied. The Member and Provider will also receive an appeal form.

The Member may request an appeal orally or in writing with Community First's Population Health Management Resolution Unit. Community First will mail the Member a complaint appeal acknowledgement letter within five (5) calendar days from the date of receiving a written complaint appeal or complaint appeal form. Community First will schedule a Complaint Appeal Panel hearing.

Five (5) days before the hearing, a letter will be mailed to the Member with important information regarding his or her complaint appeal rights. The Member may appear in person before the Appeal Panel or submit written information. After the Appeal Hearing and within 30 calendar days from the date of receiving the written complaint appeal, Community First will send the Member a formal written letter explaining the decision.

If the Member is not satisfied with the outcome of the Complaint Appeal Hearing, the Member may file a complaint with the Texas Department of Insurance (TDI).

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

1-800-252-3439
Fax **(512) 475-1771**
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

A Member has a right to request an **appeal for denial of payment for services in whole or in part.** The Member may be required to pay cost of services furnished while appeal is pending.

Members who are not satisfied with the outcome of an action by Community First can appeal the decision. To do so, the Member or the Member's authorized representative must file a request for appeal within 30 days from Community First's notice of action.

However, to ensure continuity of currently authorized services, they must file the appeal on or before the later of 10 days following the Community First mailing of the notice of action or the intended effective date of the proposed action.

Community First Member Services can assist the CHIP Member in filing the appeal.

The appeal must be made in writing to Community First and mailed to the following address:

Community First Health Plans
Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

A Member or the Member's authorized representative also may call **1-800-434-2347** to request an Appeal Form or assistance with understanding Community First's appeal process.

The timeframe may be extended up to 14 calendar days if Member requests an extension; or if Community First shows that there is a need for additional information and how the delay is in the Member's interest.

The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

Every oral appeal received must be confirmed by a written, signed appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

The Population Health Management Resolution Unit at Community First will send the Member an acknowledgement of the appeal within five (5) days and a decision on the appeal within 30 days.

3. Member Expedited Appeal

Community First CHIP/CHIP Perinatal Members may request an expedited appeal if the CHIP Member is not satisfied with the denial of a covered benefit.

Community First CHIP Members may request an expedited appeal orally or in writing when Community First is required to make a decision quickly based on the Member's health status and taking the time for a standard appeal could jeopardize the Members health such as a denial of emergency care, a life-threatening condition, or an inpatient hospitalization.

Community First Member Services can assist the CHIP Member in filing an expedited appeal.

The timeframe in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one (1) working day following the date that the appeal is made to Community First.

The timeframe may be extended up to 14 calendar days if Member requests an extension; or if Community First shows that there is a need for additional information and how the delay is in the Member's interest.

Community First will notify the Member if a request for an expedited appeal is denied. The request will be moved to the regular appeal process and the Member will be notified of the change by mail within two (2) calendar days.

4. Member Independent Review Organization (IRO)

What is an IRO?

An IRO is an Independent Review Organization that is not part of Community First. The IRO reviews unresolved appeals, as coordinated by MAXIMUS Federal Services State Appeals.

CHIP Members may submit a request for an IRO to Community First's Population Health Management Resolution Unit and the Resolution Unit will forward the request to MAXIMUS Federal Services State Appeals for assignment.

Members can give MAXIMUS additional information for your external review by sending to:

MAXIMUS Federal Services State Appeals
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: **1-888-866-6190**

Members can also visit the HHS-Administered Federal External Review Process website to request a review online.

What are the timeframes for requesting, reviewing and resolution of an IRO?

The IRO must make its determination by the 15th day after the IRO receives the information necessary to make a determination, or by the 20th day after the IRO receives the request.

5. Appealing an Adverse Determination

CHIP Members who receive a denial of services are notified by mail with an appeal form enclosed. Members can ask for an appeal of the adverse determination by mail or by phoning a Member Services Representative, who can assist them. The Member must request an appeal within 60 days from the date of notification of the denial, reduction or suspension of previously authorized services, or by the effective date of the action. Community First will send the Member a letter within five (5) calendar days to acknowledge receipt of the appeal and will mail the Member the health plan's decision within 30 calendar days.

Expedited Appeals

For emergencies or hospital admissions, or to continue current prescriptions and intravenous medications, or for denial of step therapy medication protocol exception, Members can request an expedited appeal. An expedited appeal requires Community First to make a decision quickly based on the condition of the Member's health, and when taking the time for a standard appeal could jeopardize the Member's life or health.

Members may ask for an expedited appeal by phone, in person, or in writing. Members also have the right to ask for an extension of up to 14 days if you would like to provide additional information to support your expedited appeal. A Community First Member Services Representative can help request an expedited appeal. Members should call

Member Services at **1-800-434-2347** for assistance.

If Community First denies the request for an expedited appeal, the health plan will notify the Member within two (2) days that the appeal has been moved to the regular appeals process.

If Community First has all needed information, the health plan will have an answer within one (1) to three (3) days after the appeal is received.

The Member may ask for an External Review if not satisfied with Community First's decision on the appeal. Also, if Community First does not answer the regular or expedited appeal within the timelines given, the Member may request an External Review without waiting for the answer to the appeal by calling or writing MAXIMUS Federal Services at the following address:

HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

1-888-866-6205
Fax: **1-888-866-6190**

An External Review must be requested within four (4) months from the receipt of the Community First appeal decision letter. Community First will provide all the documents and information related to the denial to the External Reviewer. The External Reviewer will mail the Member and Community First the decision within 45 days after the date the examiner receives the request for External Review.

For life-threatening conditions, urgent care situations and for current prescriptions and intravenous medications, the Member can call MAXIMUS to request an expedited External Review before or after exhausting the Community First appeal process. The reviewer will send a decision as soon as possible, but no later than three (3) days after the examiner receives the request for an expedited External Review.

F. Encounter Data, Billing, and Claims Administration

1. Where to Send Claims/Encounter Data

Paper Claims

Submit paper claims to the following address:

Community First Health Plans, Inc.
P.O. Box 240969
Apple Valley, MN 55124

Community First requests that if you are submitting paper claims, the following steps be followed to expedite payment:

- Use 10 x 13-inch envelopes; send multiple claims in one envelope
- Do not staple, paper clip, or fold claim forms or attachments
- Do not use red ink
- Whenever possible, generate your claims on a computer or typewriter (handwritten claims are difficult to read and scan)

Electronic Claims

Submit electronic claims via:

- **Provider Portal.** Providers may submit batch claims or individual claims electronically using Community First's secure Provider Portal at CommunityFirstMedicaid.com.

- **Availity – Clearinghouse.** Community First accepts electronically submitted claims through Availity. Claims filed electronically must be files using the 837P or 837I format. Billing instructions can be found on the Availity website. Electronically submitted claims must be transmitted through Availity using Community First's Payor Identification as indicated below:
  - Community First Payor ID: COMMF
  - Community First Receiver Type: F

- **Provider Portal Electronic Billing:**
  - Claim MD
  - Availity

2. Claim Form

Physician and other health care providers must file paper claims on a **CMS-1500 Claim Form and Instruction Table (Exhibit 16).** Federally Qualified Health Centers (FQHC) can file on either a CMS 1500 or a UB 04.

Community First should be billed your normal (usual and customary billed) charges only. We will make the necessary adjustments and will show the adjustments made on the Explanation of Payment (EOP) sent to you with your reimbursement check.

Hospitals, Rural Health Clinics (RHC), and other facilities must bill on a **UB 04 Claim Form and Instruction Table (Exhibit 17).** See Exhibit 17 for a sample claim form and complete instructions.

NOTE: Only claims including all required information will be considered clean claims. Newborn claims should be submitted with all of the required elements above. However, if a CHIP number for the newborn is unavailable, use the mother's CHIP Member ID number with the correct date of birth for the newborn.

3. Emergency Services Claims

Community First's policies and procedures, covered services, claims adjudication methodology, and reimbursement levels for emergency services comply with all applicable state and federal laws, rules and regulations including 42 C.F.R. 438.114, whether the Provider is a participating Provider or out of network. Community First's policies and procedures are consistent with prudent layperson definition of an emergency medical condition and the claims adjudication processes required under the contract with HHSC and C.F.R. 438.114.

Community First will pay for the professional, facility, and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a Member presenting as an emergency medical condition or an emergency behavioral

health condition to a hospital emergency department, 24 hours a day, 7 days a week, rendered by either a participating Provider or an out-of-network provider.

Community First does not require prior authorization as a condition for payment for an emergency medical condition, an emergency behavioral health condition, or labor and delivery. Nor does Community First hold the Member liable for the payment of subsequent screening and treatment to diagnose the specific condition or stabilize the Member who had an emergency medical condition.

PCPs should become actively involved in educating CHIP Members regarding the appropriate use of the emergency room and other emergency services. PCPs should notify Community First of any Member who may need further education by calling Member Services.

If a Member has an emergent condition, the emergency room must treat the Member until the condition is stabilized or until the client can be admitted or transferred. Once the Member is stabilized, the emergency room staff must notify Community First to arrange for medically necessary hospital admission or follow-up care with the Member's PCP.

4. Pharmacy Claims

- Clean claims submitted electronically will be adjudicated within 18 days of receipt. Clean claims submitted non-electronically will be adjudicated within 21 days of receipt.
- Claim submission requirement (within 95 days)
- Approved claim forms

5. Cost Sharing Schedule

There are two types of cost share obligations – enrollment fees and copayments. Most CHIP-eligible households are subject to cost share obligations.

Cost Share Obligation Exceptions

- Households with gross income at or below 151% of the Federal Poverty Income Limit (FPIL) are not subject to an enrollment fee;

- American Indians and Alaska Natives are exempt from all cost sharing. American Indian or Alaska Native status is self-declared on the application. If one child within the household is an American Indian or Alaska Native, the entire household application has American Indian or Alaska Native status;

- and unaccompanied refugee minors are exempt from all cost sharing.

Cost sharing is processed by the Enrollment Broker.

CHIP Perinatal recipients are not subject to cost share obligations. Perinatal recipients do not pay enrollment fees or copayments.

Additionally, for **CHIP Members**, there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

CHIP Cost-Sharing	
	Effective January 1, 2014
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% of FPL*	**Charge**
Office Visit (non-preventative)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Copay, Inpatient (per admission)	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10

CHIP Cost-Sharing	
Brand Drug	$35
Facility Copay, Inpatient (per admission)	$75
Cost-sharing Cap	5% (of family's income)
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventative)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Copay, Inpatient (per admission)	$125
Cost-sharing Cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
**Per 12-month term of coverage.

6. Member Billing

By entering into an agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services rendered to Members. **By contract you cannot bill Members for the difference between your normal charge and the payment rate that you negotiated with Community First for rendering covered services.**

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

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

- Failure to submit a claim, including claims not received by Community First
- Failure to submit a claim to Community First for initial processing within the 95-day filing deadline
- Failure to submit a corrected claim within the 120-day filing re-submission period

- Failure to appeal a claim within the 120-day appeal period

Payment for Services

The Provider is prohibited from billing or collecting any amount from a Medicaid Member for "health care services" rendered pursuant to the provider contract. Federal and state laws impose severe penalties for any Provider who attempts to bill or collect any payment from a Medicaid recipient for a covered service.

The Provider understands and agrees that HHSC is not liable or responsible for payment of covered services rendered pursuant to the provider contract.

7. Time Limit for Submission of Claims

Providers are required to submit claims to Community First ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Provider Relations at **(210) 358-6030**.

Proof of Timely Filing

Community First accepts the following as proof of timely filing:

- Returned receipt (Certified Mail)
- Electronic confirmation from Community First vendor
- Receipt of claim log signed by Community First employee

5. Claims Submission

Community First will provide the Provider at least 90 days' notice prior to implementing a change in the above-referenced claims guidelines unless the change is required by statute or regulation in a shorter timeframe.

Providers are required to submit claims to Community First ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment.

Questions regarding claims should be directed to Community First Health Plan's Provider Services at **(210) 358-6030**.

1. Community First will adjudicate all clean claims within thirty (30) days from the date Community First receives the clean claim(s).

2. Community First will notify Providers within thirty (30) days from the date we receive the claim(s) if we will deny or pend the claim(s) and the reason(s) for the denial.

3. Community First will pay Providers interest on any clean claim(s) we do not adjudicate within thirty (30) days from the date Community First receives the clean claim(s). Community First will pay the interest at a rate of 1.5 percent per month (18 percent annually) for each month we do not adjudicate within 30 days.

Unless otherwise specified in the Professional Provider Agreement, the payment methodology applicable to the Provider is:

- One hundred percent (100%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network for Community First , the applicable payment methodology is defined by HHSC and is equal to ninety-five percent (95%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network and out of the Bexar Service delivery area, the applicable payment methodology is defined by HHSC and is equal to one hundred percent (100%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.

The Texas CHIP Fee Schedule is available at www.thmp.com and by calling **1-800-925-9126**.

Program Violations

Arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G. *Network*.

Supervised Providers

Providers must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.

9. EOP, Duplicate Checks, and Canceled Check Requests

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

NOTE: Check printing errors that result in duplicated checks should be reported to Community First as soon as identified. Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed. Any bank fees that Provider accrues after Provider deposits or cashes a duplicate check will not be reimbursed by Community First.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of $15.00 per EOP and $20.00 per check. The request for a copy of the EOP and/or check must be submitted in writing along with the appropriate fee. The request must include the date of the EOP, the name of Provider, and date of the check. Send the request to the following address:

Community First Health Plans
Attention: Claims Department Secretary
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

10. Special Billing

The following special billing guidelines are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. **Always** use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.
- The name of your claim should be the same name as it appears on the Your Texas Benefits CHIP card.
- Make sure the sex of the Member listed on the claim is accurate
- Value-added services do not require billing.

11. Billing and Claims Administration

Coordination of Benefits

A third party may cover some CHIP Members (e.g., auto liability, disability, or workers' compensation). In situations where a CHIP Member has other insurance, the other insurance carrier will be the primary payor. Providers must bill the third-party insurance first, and then attach a copy of the Explanation of Benefits (EOB) statement received from the third-party insurance to the claim when filing with Community First for reimbursement. Providers must file claims to Community First within ninety-five (95) days of the third-party insurance EOB. As a payor for Medicaid services, Community First will act as the payor of last resort. Community First will deny payment for claims that do not include proof of prior filing with the CHIP Member's third-party insurance. If a CHIP Member indicates they do not have a third-party insurance, instruct the Member to contact Community First's Member Services Department for assistance.

Third Party Recovery

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

Explanation of Payment (EOP)

You will receive an **Explanation of Payment (EOP) – Sample (Exhibit 19)**. The EOP will include the following information:

- Amount billed
- Allowed (contracted) amount
- Other insurance payment
- Total benefit paid to the Provider
- All reasons for the denial if payment is not made

Claims Reconsideration

If you disagree with the manner in which the claim was adjudicated, send the corrected claim and/or letter with a copy of the EOP to the claims address listed at the beginning of this section.

Appeals of "For Cause" HMO Agreement Termination

Community First must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider, including an STP. At least 30 days before the effective date of the proposed termination of the Provider's contract, Community First must provide a written explanation to the Provider of the reasons for termination. Community First may immediately terminate a Provider contract if the Provider presents imminent harm to patient health, actions against a license or practice, fraud or malfeasance.

Within 60 days of the termination notice date, a Provider may request a review of Community First's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license, fraud or malfeasance. The advisory review panel must be composed of physicians and Providers, as those terms are defined in §843.306 Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Community First. The decision of the advisory review panel must be considered by Community First but is not binding on Community First. Community First must provide to the affected Provider, on request, a copy of the recommendation of the advisory review panel and the Community First's determination.

According to your agreement with Community First, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The

agreement also states that it will terminate immediately and without notice under certain circumstances. If we give you a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure. This procedure is available only if we are terminating your agreement for the reasons stated above.

Providers may not offer or give anything of value to an officer or employee of HHSC or the state of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First may terminate the Provider's contract at any time for violation of this requirement.

Notice of Proposed Action

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

Upon termination of your agreement, you may request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to Community First's Medical Director. You should include any explanation or other information with your request for reinstatement. The Community First's Medical Director will appoint a committee to review your request, and any information or explanation provided within thirty (30) days of receipt. The committee will recommend an initial decision to the Board of Directors either to terminate your Membership and reaffirm your agreement, reaffirm with sanctions, or to revoke.

Decision

Within ten (10) days of receiving the committee's recommendations Community First will, by special notice in registered or certified mail, inform you of Community First's decision on your request for reinstatement. This decision will be final.

12. Claims Questions/Appeals

Providers have the right to appeal the denial of a claim by Community First. The Provider has **90 days** from the date of the most recent Community First's EOP to appeal the denial. Community First will not accept any appeal submitted after the appeal deadline or appeals older than two (2) years. Providers may submit a **Claim Appeal Submission Form (**Exhibit 21**)**, via mail to the following address:

Community First Health Plans, Inc.
Attention: Claims Appeal
P.O. Box 240969
Apple Valley, MN 55124

Providers can also submit the appeal request electronically using Community First's secure Provider Portal.

Please direct any claim questions regarding appeals to Community First Health Plans by calling **(210) 358-6030.**

13. Electronic Funds Transfer and Electronic Remittance Advice

Community First partners with PaySpan for EFT and ERA.

G. Special Access Requirements

1. Interpreter/Translation Services

Community First Member Services includes representatives who can speak to Members in English or Spanish, or we can get an interpreter who speaks their languages.

Community First has interpretive services available for its CHIP Members to ensure effective communication regarding treatment, medical history or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide Community First CHIP Members access to professionals trained to help with technical, medical or treatment information when a family

Member or friend interpreter is inappropriate. To arrange for a sign interpreter or language interpreter for a Community First CHIP Member, please contact Community First's Member Services Department at **(210) 358-6300**.

2. Community First and Provider Coordination

Community First will make every effort to communicate with and coordinate the delivery of Covered Services with a CHIP Member's PCP. Community First will provide each PCP and his/her staff with a current Provider Manual and revisions within five days of becoming network participants. Provider orientations will be completed within 30 days of the PCP becoming a network participant. Additionally, routine office visits will be made by assigned Provider Relations staff to answer any questions or concerns and to review critical elements with the physician and his/her staff.

Community First will operate a toll-free telephone line **1-800-434-2347** for Providers from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday. The Provider Hotline will be staffed with personnel who are knowledgeable about Covered Services for CHIP, about non-capitated services, and general health plan operations to assist the Provider.

3. Reading/Grade Level Consideration

Community First prints all CHIP Member materials in both English and Spanish at a 6th grade reading comprehension literacy level.

4. Cultural Sensitivity

Community First recognizes the diversity of the population in the CHIP Program and has programs to support a multi-cultural Membership. We staff Community First's Member Service Department with knowledgeable, bilingual (English/Spanish) Member Service Representatives to help CHIP Members with questions.

2024
CHIP PROVIDER MANUAL

COMMUNITY FIRST HEALTH PLANS

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