COMMUNITY FIRST HEALTH PLANS

TEXAS STAR Your Health Plan ★ Your Choice

TEXAS Health and Human Services

2024 STAR PROVIDER MANUAL

COMMUNITY FIRST PROVIDER RELATIONS

PROVIDER SERVICES 210-227-2347

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I. INTRODUCTION

Welcome to the Community First Health Plans STAR Network.

A. Background and Objectives of Program

Community First's STAR (State of Texas Access Reform) benefit program is a managed care option of the Texas Health and Human Services (HHSC) STAR Program for Medicaid clients.

The objectives of the STAR Program are to improve access to care for Members, as well as to increase the quality and continuity of care for Members. In addition, the STAR Program aims to decrease inappropriate usage of the health care delivery system, such as emergency room visits for non-emergencies; to achieve cost-effectiveness and efficiency for the state; and to promote Provider and Member satisfaction. Community First is able to ensure these objectives are accomplished because of its diverse, fully credentialed network of Physicians, allied health care Providers, ancillary Providers, and hospitals.

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

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

In addition, Community First STAR 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 manual is to assist you and your staff in working with us to deliver quality health care to Community First STAR 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 Network Management 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 will publish and distribute a semi-annual newsletter to all network physicians and Providers. The newsletter will include information such as STAR services, policies and procedures, statutes, regulations, and claims processing information. Community First also uses fax alerts, banner messages, special mailings, and our web site as additional means to communicate changes/updates to you and your staff.

Following the initial orientation session for Community First STAR 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 STAR Program requirements, including changes to covered services, authorization requirements, and claims submission procedures and/or appeal timeframes.

B. Quick Reference Phone List

Listed below are important telephone numbers for you to use when you need to reach Community First.

Member Services Member Services Fax	1-800-434-2347 210-358-6099
Population Health Management Preauthorization Fax	210-358-6050 210-358-6040
Urgent Care	210-227-2347
Behavioral Health Authorization/Case Management Behavioral Health Fax	210-358-6403 1-800-434-2347 Option 3 210-358-6387
NICU Fax	210-358-6388
Member Services Eligibility/Benefits Verification	210-358-6060
Interpreter Services (sign and language)	1-855-607-7827 1-800-246-2686
TTY (for the hearing impaired)	711
Network Management Network Management Fax	210-358-6030 210-358-6199
Claims Information: Claims Fax Electronic Claims	210-358-6200 210-358-6014 Availity Payor ID: COMMF
Nurse Advice Line After Hours (After-hours calls to Community First are forwarded to the Nurse Advice Line.)	1-800-434-2347
Preventive Health & Disease Management Preventive Health & Disease Management Fax	1-800-434-2347 Option 9 210-358-6099
Community Outreach Agencies	210-358-6159
Pharmacy-Navitus Health Solutions	1877-908-6023
Vision-Envolve Benefit Options	1-800-334-3937
Dental Inquiries: United Healthcare Dental DentaQuest MCNA Dental	 877-901-7321 800-516-0165 855-691-6262

C. Role of the Primary Care Physician (Medical Home)

PCPs play an integral role in helping meet the objectives of the STAR 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 STAR 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 STAR Members by

- Serving as a Medical Home to STAR Members
- 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

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.

PCPs must provide preventive care to children under age 21 in accordance with the American Academy of Pediatrics recommendations for THSteps periodicity schedule published in the THSteps Provider Manual, Children's Handbook section and to adults in accordance with the U.S. Preventive Task Force requirements.

The PCP must obtain the STAR Member's consent when seeking services from a Physician Assistant or Nurse Practitioner **(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's 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 STAR 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
- THSteps
- Case Management for Children and Pregnant Women (CPW)
- School Health and Related Services (SHARS)
- Department of State Health Services Case Management (DSHS)
- THSteps Dental
- 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 Case Management Services
- Early Childhood Interventions (ECI) Case Management Services
- Targeted Case Management
- SHARS
- Texas Commission for the Blind Case Management Services
- THSteps Medical Case Management
- THSteps Dental (including orthodontics)
- 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)**. Questions regarding this process may be directed to Community First's Network Management Department.

D. Role of the Specialty Care Physician

The specialty care physician is responsible for providing medically necessary services to Community First STAR 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.

E. Network Limitations

A STAR 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 STAR 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 STAR Member may not be allowed to receive service from any physician or health care professional that is not part of the PCP's network (excluding OB/GYN and Behavioral Health Providers).

F. Providers for STAR 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 STAR 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 STAR 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 STAR 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 the Population Health Management at **210-358-6050.**

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

1. Certification by the non-primary care physician specialist as a PCP.

2. A signed statement by the non-primary care Physician specialist that he or she is willing to accept responsibility for the coordination of all the Member's health care needs including referrals to other specialists.

3. The signature of the Member concurring with the request.

G. Role of Pharmacy

The pharmacy is responsible for providing pharmaceutical services to Community First STAR Members. Pharmacies must verify the eligibility of the Member prior to rendering services. Pharmacies 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.
- Coordinating benefits when a Member also receives Medicare Part D services or other insurance benefits.

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.

H. 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 the 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 timely choose one. Whether chosen or assigned, each Member who is six months or older must have a designated main dental home.

I. 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.

J. Medical Record Standards

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 of 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 HHSC the following, at no cost:

- 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.
- 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.
- 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 § 371.1701-371.1719.

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 STAR 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.

K. 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.

II. LEGAL AND REGULATORY

A. Laws, 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 that the following laws, rules, and regulations, and all subsequent amendments or modifications thereto, apply to the Provider contract:

1. Environmental Protection Laws

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

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

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

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

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

2. State and Federal Anti-Discrimination Laws

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

b. 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.).

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

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

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

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

B. 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's Members may not be held liable for Community First's debts in the event of Community First's insolvency.

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. Prac. & Rem. Code § 101.001 et seq.).

C. Medical Consent Requirements

Providers must comply with medical consent requirements in FAM § 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 FAM § 266.009.

D. 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.

E. Reporting Abuse, Neglect, or Exploitation

Report Suspected Abuse, Neglect, and Exploitation (ANE)
Community First and Providers 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 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 if the victim is an adult or 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.
- Adult day care centers.
- Licensed adult foster care providers.

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:

- An adult or 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 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 (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 (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.

F. Potentially Preventable Complications (PPC) and Provider Preventable Readmissions (PPR)

Potentially preventable complications (PPC) 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.

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.

III. COVERED SERVICES

The following is a list of Covered Services:

- Ambulance services
  Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health services, including:
  - Screening
  - Inpatient hospitalization (free standing hospital and general acute-care hospital and TCADA licensed facilities)
  - Treatment by psychiatrists, psychologists, LPCs, LCSW-ACPs, LMFTs, and LCDCs
  - Chemical dependency outpatient counseling
  - Outpatient Behavioral Health counseling services are available for all STAR Members
- Birthing center services if available within the service area
- Case Management for Children and Pregnant Women (CPW Service Coordination)
- Chiropractic services
- Dialysis
- Durable Medical Equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the THSteps Program
- Non-Emergency Medical Transportation Services (NEMT).
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty Physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

For a full listing of benefits and service including exclusions, please see the Texas Provider Procedures Manual at www.tmhp.com.

In addition to the standard covered benefits, Community First STAR Members are eligible for the following benefits:

- Annual adult well checks
- Removal of the Spell of Illness limitation
- Unlimited prescriptions for adults

A. THSteps Services

1. Overview

The Texas Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid recipients who are the ages of birth through 20. In Texas, the EPSDT program is known as THSteps. THSteps is administered by the Texas Department of State Health Services (DSHS).

The information presented here is an overview that supplements the approved HHSC current year version of the "Texas Medicaid Provider Procedures Manual," and specifically, the THSteps Section, and Texas Medicaid bi-monthly bulletins. Providers are referred to these publications for detailed information about the program.

THSteps Medicaid providers must perform medical checkups on any clients currently enrolled in Medicaid and who are the ages of birth through 20. Providers also are encouraged to notify the client when he or she is due for their next medical checkup according to the THSteps Periodicity Schedule.

Community First covers medical checkup services for persons who are ages of birth through 20 years of age and when delivered according to the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the STAR Member's life and identifies the period, based on the STAR Member's age when medical checkup services are reimbursable.

The STAR Member's age on the first day of the month determines the STAR Member's eligibility for a medical checkup. If a STAR Member has a birthday on any day, except the first day during the month, the new eligibility period begins on the first of the following month. When a STAR Member turns 21 years old during a month, the STAR Member continues to be eligible for THSteps services through the end of their birthday month.

Providers are responsible for documenting in office records that the previous year's medical checkup was completed. This documentation can be based on the STAR Member's previous medical record or verbal information given by the STAR Member or responsible adult.

Benefits: Providers are to check the STAR Member's Texas Benefits Medicaid Card to determine periodic eligibility. A "message" under the STAR Member's name indicates the THSteps service for which the STAR Member is currently eligible. A checkup provided when a THSteps statement does not show that a medical checkup is due is considered an Exception-to-Periodicity Schedule.

An alternate verification process allowed by Community First is our secure Provider web portal. Member eligibility may be verified on the date of service using this portal. Providers must make a screen print of the Member eligibility record on the date that services are rendered by the Provider and retain this copy. If a Provider does not have a login to access Community First's Provider web portal, contact your Community First's Network Management Provider Representative.

NOTE: Newly enrolled STAR Members must receive a THSteps medical checkup within 60 days from enrollment.

Community First's Network PCPs must:

- Be enrolled as THSteps providers or refer Members due for a THSteps checkup to a THSteps provider.
- Refer Members for follow-up assessments or interventions clinically indicated as a result of the THSteps checkup, including the developmental and behavioral components of the screening.
- Submit information from the THSteps forms and documents to the Member's medical home.

2. Provider Enrollment

To enroll in the THSteps Program, Providers must be enrolled in Texas Medicaid and be one of the following:

- Licensed Physicians (MD, DO)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Health care Providers of facilities (public or private) that can perform the required medical checkup procedures only under the supervision of a Physician.

- Advanced Practice Nurses (APNs) may enroll independently as THSteps Providers if they are recognized by the Texas BON and nationally certified in at least one of the following:
  - **a.** Family Practice
  - **b.** Pediatrics
  - **c.** OB/GYN
  - **d.** Adult Health (adults only)
  - **e.** Women's Health (adolescent females only)
- Certified Nurse-Midwives (newborn and adolescent females only)
- Physician Assistants (PAs) (recommended that a PA have expertise or additional education in the areas of comprehensive pediatric assessment)

Residents may provide medical checkups in a teaching facility under the personal guidance of the attending staff as long as the facility's medical staff bylaws and requirements of the Graduate Medical Education (GME) Program are met and the attending Physician has determined the resident to be competent to perform these functions.

A registered nurse (RN) may perform THSteps checkups only under the supervision of a Physician. The Physician ensures that the RNs have appropriate training and adequate skills for performing the procedures for which they are responsible. THSteps requires that all RNs performing THSteps medical checkups complete the online education modules developed by the THSteps Program. THSteps online education modules may be accessed at www.txhealthsteps.com. Before a Physician delegates a THSteps checkup to an RN, the Physician must establish the RN's competency to perform the services required by the Physician's scope of practice. The RN or employer must maintain documentation that the available required courses were completed.

Medicaid providers, except Federally Qualified Health Centers (FQHCs) and/or a provider associated with a group, who want to become THSteps providers, must enroll separately as a THSteps medical checkup provider. (A Medicaid group must enroll as a THSteps medical checkup provider in lieu of each provider within the group enrolling separately). The individual and/or group will be assigned a THSteps Texas Provider Identifier (TPI) suffix to their Medicaid provider number. For more information, call Texas Medicaid and Healthcare Partnership (TMHP) customer service at **1-800-925-9126** or **512-514-3000**.

Providers who desire to only make referrals to Medicaid providers or who are only going to order or prescribe for DME, supplies, or prescriptions that

are a covered Medicaid benefit, but who do not wish to participate as a full Texas Medicaid enrolled provider, may complete an abbreviated enrollment form through TMHP. For further information on this process please contact the TMHP customer service department at **800-925-9126** or **512-514-3000**.

3. THSteps Checkups

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined in the THSteps Periodicity Schedule based on age and include:

a. **Comprehensive health and developmental history**, which includes nutrition screening, developmental and mental health screening, and TB screening. A complete history includes family and personal medical history, along with developmental surveillance and screening, and behavioral, social, and emotional screening. The THSteps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.

b. **Comprehensive unclothed physical examination,** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening. A complete exam includes the recording of measurements and percentiles to document growth and development, including fronto-occipital circumference (0-2 years) and blood pressure (3-20 years). Vision and hearing screenings also are required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

c. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.

- Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza, and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States" **(Exhibit 23)**, unless medically contraindicated or because of parental reasons of conscience, including religious beliefs.
- The screening Provider is responsible for administration of the immunization and are not to refer children to other immunizers, including local health departments.

- Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Tex. Health & Safety Code Chapter 161, relating to the Texas Immunization Registry (ImmTrac).
- Providers may enroll, as applicable, as Texas Vaccines for Children Providers. For information, please visit www.dshs.texas.gov/vaccines-children-texas

d. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.

- Newborn Screening: Send all THSteps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the hospital with screens performed at the newborn follow-up THSteps medical checkup.
- Anemia screening at 12 months.
- Dyslipidemia Screening at 9 to 12 years of age and again at 18 to 20 years. HIV screening at 16 to 18 years.
- Risk-based screenings include dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis, and gonorrhea/chlamydia.

e. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers, and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents, and disease.

f. **Dental referral** every six (6) months until the parent or caregiver reports a dental home is established. Clients must be referred to establish a dental home beginning at six months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional but recommended. Each checkup form includes all checkup components, screenings that are required at the checkup, and

suggested age-appropriate anticipatory guidance topics. These forms are available online in the resources section at www.txhealthsteps.com.

Each of the six components and their individual elements, according to the recommendations established by the THSteps Periodicity Schedule for children and as described in the Texas Medicaid Provider Procedures Manual, must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

4. Additional THSteps Program Details

THSteps staff, through outreach programs and information, encourage STAR Members to use "THSteps Periodicity Schedule" **(Exhibit 8)** when they first become eligible for Medicaid. The components and elements of the THSteps' checkup and immunization visits are based on the American Academy of Pediatrics (AAP) Periodicity Schedule but are modified to meet the state of Texas and federal regulations. Further information can be found in the following publications: "Texas Medicaid Provider Procedures Manual," "Children's Services Handbook," "THSteps Medical Section," and Texas Medicaid Banner messages.

a. Farmworkers

Traveling farmworkers due for a THSteps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as an Exception-to-Periodicity checkup.

Performing a make-up exam for a late THSteps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

b. Reimbursement - Medical Checkup

Community First reimburses Providers for performing a complete medical checkup and for administration of immunizations at the maximum fee allowed by HHSC. The THSteps Periodicity Schedule identifies the required components/elements that Providers must perform during a THSteps medical checkup based on the age of the child.

NOTE: Community First will not reimburse Providers for incomplete medical checkups.

If the medical checkup provider identifies a condition that requires follow-up evaluation, diagnosis, and management:

- The Provider may provide treatment of the identified condition if the Provider performing the THSteps medical checkup is the Community First STAR Member's PCP.A separate claim for an **established** client office visit may be submitted on the same day as the checkup with an appropriate established client CPT code for the diagnosis and treatment of the identified condition. Every medical checkup will not have a related claim for the evaluation and management of an identified condition. Often minor illnesses and/or conditions (e.g., follow-up of a mild URI) during the THSteps checkup do not warrant an additional billing for further diagnosis and treatment.

- The Provider **must** refer the Member to their PCP to obtain evaluation and management of any identified conditions if the Provider performing the THSteps checkup is **not** the Community First STAR Member's PCP.

The THSteps medical checkup fee includes payment for TB skin tests and collection of blood specimens for all THSteps required laboratory services included on the medical checkup periodicity schedule. Childhood immunization vaccines and laboratory supplies and testing are available at no cost to THSteps checkup providers through DSHS. An administration fee is paid for each immunization given during a THSteps checkup or as part of a follow-up claim, except for services performed in an FQHC or RHC setting. The immunization administration fee is reimbursed at the maximum allowable fee established by HHSC (rates vary based on the number of state-defined components administered for each injection).

c. Newborn Examination

Providers can bill inpatient newborn examinations with newborn CPT codes 1-99460 and 1-99461 which are considered THSteps medical checkups and include the required medical checkup components as designated on the THSteps Medical Checkup Periodicity Schedule for inpatient newborn infants. This includes a history and physical, with length, height, weight, and head circumference, sensory screening (vision/hearing) Hepatitis B immunization, initial newborn screen at 24-48 hours of age, and health education/anticipatory guidance with the parents or responsible adult. (Health education by the nursing staff, individually or in a class, is acceptable.)

d. Newborn Hearing Screening

Tex. Health & Safety Code Chapter 47 states that the hearing screening must occur at the birthing facility before the newborn is discharged from the hospital. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with Texas Department of Licensing and Regulation (TDLR) standards (www.tdlr.texas.gov/slpa/slpa.htm), and notification to the Provider, parents, and TDLR of screening results. There is no additional Medicaid reimbursement for the hearing screening as the procedure is part of the newborn DRG. Hospitals should use the current ICD-1010-CM procedure code for a hearing examination, not otherwise specified, to report this newborn hearing screen.

This facility-based screening also meets the physician's required components and elements for hearing screening in the inpatient newborn THSteps checkup. The physician must ensure that the hearing screening is completed before discharging the newborn or, when the birthing facility is exempt under the law, there is an appropriate referral for hearing screening to a birthing facility participating in the newborn hearing screening program. The Physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to TDLR for tracking and follow-up purposes. If a physician has any concerns about this process, contact the hospital administrator or the TDLR Audiology Services program.

If a Provider chooses to do a brief examination (not including all of the above components), the Provider may bill the new HCPCS code: 1-99431 or 1-99432 with modifier-52, which will not count as a THSteps checkup.

Community First encourages physicians and hospital staff to inform parents of children eligible for Medicaid's THSteps to schedule an outpatient visit for the next THSteps medical checkup at one to two weeks of age, and to schedule the regular medical checkups as recommended by the THSteps Periodicity Schedule.

Clients Ages 4 to 20 - Objective Screening
All clients who are four, five, six, eight, and 10 years of age must be screened for hearing loss with pure tone audiometric threshold screening. **Pure tone audiometric threshold screening also must be performed upon parental request.**

e. THSteps Medical Checkup Follow-up Visit

If a component/element of the medical checkup cannot be completed because of a medical contraindication of a Member's condition, then a follow-up visit will be necessary. The Provider must document the reason the component(s) was not completed and schedule a follow-up visit, CPT code 9921l. Community First reimburses for one follow-up visit, when required, at the maximum allowable fee established by HHSC (e.g., redraw of lab specimens).

5. Documentation Requirements

All THSteps services require documentation to support the medical necessity of the services rendered including THSteps medical services. THSteps services are subject to retrospective review and recoupment if documentation does not support the services billed.

The STAR Member's record must reflect that each of the required screening procedures, based on the STAR Member's age, was completed in accordance with the medical checkup periodicity schedule.

a. Training:

- THSteps has developed online educational modules to provide additional information about the program, components of the

medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps.

- These courses may be accessed at www.txhealthsteps.com.
- Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. To obtain free vaccines for clients who are birth through 18 years of age, THSteps providers must enroll in TVFC at DSHS. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however, the administration fee, not to exceed the current allowable reimbursement.

THSteps providers should encourage clients to see their primary care provider as their medical home. If the client's primary care provider is not a THSteps medical provider, the checkup provider must send the primary care provider the records from all THSteps medical checkups performed for the client. **All primary care providers are encouraged to enroll as THSteps medical providers.** This allows the client to receive both acute care services and preventive THSteps services from the same Provider.

The following includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral is made or not. If a referral is made, then Providers must use the "Y" (yes) referral indicator. If no referral is made, then Providers must use the "N" (no) referral indicator.

- A checkup must be submitted with diagnosis code Z00121 or Z00129.
- Procedure Codes Referral Indicator Condition Indicator:
  - 99381, 99382, 99383, 99384, and 99385 (new client preventive visit) or
  - 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)
- N: (no referral given)
- NU: (not used)
- Y: (THSteps or EPSDT referral was given to the client)
- S2 (under treatment) or ST* (new services requested)

- When performed for a THSteps preventive care medical checkup, procedure codes 99385 and 99395 are restricted to clients who are 18 to 20 years of age.
- Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

* The ST condition indicator should only be used when a referral is made to another Provider or the client must be rescheduled for another appointment with the same Provider. It does not include treatment initiated at the time of the checkup.

b. Modifier Practitioner

- AM: Physician
- SA: Advance Practicing Nurse rendering service in collaboration with a Physician
- TD: Registered Nurse
- U7: Physician Assistant

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter including any immunizations or developmental screening procedures. When submitting claims for THSteps checkups and services, RHC providers must use the national place-of-service (POS) code 72, and FQHC Providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a Physician's interactions with the client.

Modifier	Description
SC	Medically necessary service or supply.
23	Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier "-23" to the procedure code of the basic service or by use of the separate 5-digit modifier code 09923.
32	Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "-32" to the basic procedure or the service may be reported by use of the 5-digit modifier code 09932.

Use procedure code 99211 with the THSteps Provider identifier and THSteps benefit code when billing for a follow-up visit.

A follow-up visit may be required to complete necessary procedures related to a THSteps medical checkup or exception-to-periodicity checkup, such as:

- Collection of specimens for laboratory testing that were not obtained during the original THSteps medical checkup or the original specimen could not be processed.
- Completing sensory or developmental screening that was not completed at the time of the THSteps medical checkup due to the client's condition.

Required Screening Ages and Recommended Tools		
Screening Ages	**Developmental Screening Tools**	**Autism Screening Tools**
9 months	Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS)	
1 year	ASQ or PEDS (if not completed at 9 months or with Provider/parental concern)	
18 months	ASQ or PEDS	Modified Checklist for Autism for Toddlers (MCHAT)
24 months	ASQ or PEDS	Modified Checklist for Autism for Toddlers (MCHAT), if not performed at 18 months.
30 months	ASQ or PEDS (if not completed at 24 months or with Provider/parental concern)	
3 years	ASQ, Ages and Stages Questionnaire-SE (ASQ-SE), or PEDS	
4 years	ASQ, ASQ-SE, or PEDS	

c. Administrations and Immunizations

Providers must not refer clients to the local health department or other entity for immunization administration. Vaccines/toxoids must be obtained from TVFC for clients who are birth through 18 years of age.

d. THSteps Behavioral Health

Providers who are PCPs must use the THSteps Behavioral Health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Members must be screened for behavioral health problems, including possible substances abuse or chemical dependency. The PCP must submit completed THSteps screening and evaluation results to Community First to include in the Health Passport.

6. DSHS TH Steps Laboratory Services

Laboratory supplies and laboratory testing are available at no cost to THSteps providers through the DSHS Laboratory. You may contact the DSHS Laboratory at **1-888-963-7111 ext. 6030**.

a. THSteps Medical Checkups Laboratory Procedures

Providers may not bill the following laboratory services separately or with an office visit or consultation on the same day as a THSteps visit:

Procedure Code	Description
5-80061 *	Lipid Panel
5-82465 *	Cholesterol serum; total
5-82947 *	Glucose, Quantitative, Blood (except regent strips)
5-82952 *	Glucose, Tolerance test, each additional beyond three specimens
5-83020	Hemoglobin Electrophoresis
5-83021	Hemoglobin fractionation and quantitation; chromatography
5-83655	Lead
5-83718*	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
5-84478 *	Triglycerides
5-85014	Hematocrit (Hct)
5-85018	Total Hemoglobin (Hgb)
5-86403	Particle agglutination; screen, each antibody
5-86592	Syphilis; qualitative (e.g., VDRL, RPR, ART)
5-86689	HIV confirmation (Western blot)
5-86701	HIV-1
5-87490	Chlamydia (direct probe)
5-87590	Gonorrhea (direct probe)
5-88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
5-88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
5-88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under Physician supervision
5-88147	Cytopathology smears, cervical or vaginal; screening by automated

Procedure Code	Description
	system under physician supervision
5-88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
5-88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
5-88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
5-88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
5-88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
5-88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
5-88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
5-88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
5-88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
5-88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
5-88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
* Denotes lab codes that Provider can send to a laboratory of their choice (not required to submit to DSHS laboratory).	

These services and supplies are limited to THSteps checkup laboratory services provided in a medical checkup to THSteps Members. Unauthorized use of services and supplies are a violation of federal regulations.

b. Laboratory Supplies

- The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled Providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen requisition forms are routed to the DSHS Laboratory reporting staff and mailed separately to the Providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.
- To obtain a THSteps (Child Health Laboratory Supplies Order Form), Providers can call **1-888-963-7111, ext. 7661,** or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

c. Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

NOTE: For newborn screenings, only the specimen collection form (NBS-3), mailing envelope, and Provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.

To obtain a Newborn Screening Supplies Order Form, Providers can call **1-888-963-7111, ext. 7661**, fax **(512) 776-7672**, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm

d. Laboratory Submission

All required laboratory testing for THSteps clients must be performed by the DSHS Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for Type 2 diabetes, hyperlipidemia, HIV, and syphilis screening may be sent to the laboratory of the Provider's choice or to the DSHS Laboratory in Austin if submission requirements can be met.

- Specimens for cervical cancer, gonorrhea, and chlamydia screening are processed by the Women's Health Laboratories (WHL) in San Antonio, TX. Information regarding collection, handling, and submission of these specimens is available from the WHL.

Providers must send all THSteps newborn screens to the Texas Department of State Health Services (DSHS), formerly the Texas Department of Health, Bureau of Laboratories, or a DSHS-certified laboratory. Providers must include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.

THSteps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Request Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client's name and Medicaid number as they appear on the Texas Benefits Medicaid Card. If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form 1027-A] as eligible for Medicaid), Providers must write "pending" in the Medicaid number space, which is located in the payor source section of the Laboratory Specimen Submission Form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word "pending" written on the accompanying specimen submission form will be analyzed, and the Provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, Providers can refer to the DSHS Laboratory web page at www.dshs.state.tx.us/lab/MRS_specimens.shtm

NOTE: If an extreme health problem exists and telephone results are needed quickly, Providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of

specimens and are reported to the submitter by telephone within one hour of confirmation.

The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels to the following address:

DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803

Phone: **1-888-963-7111, ext. 7318**
Fax: **(512) 458-7294**

THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at the following address:

DSHS Laboratory Services Section, MC-1947
1100 West 49th Street
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to the following address:

Texas Department of State Health Services
Laboratory Services Section
PO Box 149341
Austin, TX 78714-9341

Providers may order supplies for Pap smears from the following address:

Women's Health Laboratories
1100 West 49th Street
Austin, TX 78756-3199

Phone: **(512) 776-7318**

Use order Form AG-30 or 1643 or letterhead stationery and include your THSteps provider number.

THSteps forms are located online at https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms

The Texas Benefits Medicaid Card
www.YourTexasBenefits.com
1-800-252-8263

7. Billing Information for THSteps

Providers should bill their usual and customary fees. Community First will reimburse Providers the lesser of the billed amount or the maximum allowable fee set forth by HHSC. Electronic claims are accepted by Availity and should be transmitted through Availity using Community First's Payor Identification.

EDI electronic data interface:

- Availity Payor ID: COMMF
- Availity Receiver Type: F

Provider Portal Electronic Billing:

- Claim MD
- Availity

Providers must be certain that all information is accurate.

a. For Electronic Submission

- The Billing and Rendering Provider's NPI and taxonomy code (which have been attested with the state) are included. (A group NPI and taxonomy code may be included in lieu of the Rendering/Performing Provider's NPI/taxonomy code if the group has attested as a "THSteps Clinic/Provider.")
- The diagnosis code Z00121 or Z00129
- Type of service will always be "S."
- Place of service will always be "1" or alpha "O."
- Place of service on the UB-04 (locator 44) is auto plugged based on the type of bill indicated on the claim.

The STAR Member's record must reflect that each of the required screening procedures, based on the STAR Member's age, were completed in accordance with the medical checkup periodicity schedule.

b. For Paper Submission

- The Provider's NPI (CMS-1500 (block 24-J) is included. Provider must have attested a TPI with the NPI submitted on the claim. (A group NPI may be included in lieu of the Rendering/Performing Provider's NPI if the group has attested as a "THSteps Clinic/Provider.")
- The diagnosis code on the CMS-1500 (block 21.1) and on the UB-04 (locator 67) will always be Z00121 or Z00129.
- Type of service on the CMS-1500 (block 24C) and on the UB-04 (locator 44) will always be "S."
- Place of service on the CMS-1500 (block 24B) will always be "1" or alpha "O."
- Place of service on the UB-04 (locator 44) is auto plugged based on the type of bill indicated on the claim.

c. THSteps Medical Checkup Code Modifiers

When using a CMS-1500 for billing THSteps services, the place-of-service will always be "1" Or alpha "O." Providers who use a UB-04 claim form for billing THSteps services will use the "appropriate type of bill" in block four (4) of the form. Record the following Provider type modifier codes in block 24 of the CMS-1500 and block 44 of the UB-04 claim form to identify who performed the physical examination of the medical checkup.

d. THSteps Medical Checkup Procedure Codes

Providers must record the following procedure codes on the CMS-1500 or UB-04 claim form to receive reimbursement for a medical screen:

- Appropriate THSteps medical checkup or follow-up visit code with appropriate modifier designating type of Provider that rendered unclothed physical, and/or exception to periodicity modifier, if applicable.
- Appropriate immunization administration code(s) with appropriate modifiers designating state-defined components, if applicable. One initial administration code must be submitted for the first vaccine. Additional administration code(s) must be submitted if more than one vaccine is administered.
- Immunization code(s) administered.
- CPT code for TB skin test code (one year through 20 years old), if

administered.

e. THSteps Medical Checkup Procedure Codes

Procedure Code	Description
S-99381	Initial comprehensive preventive medicine E & M of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age younger than one year old).
S-99382	Early childhood (ages 1-4 years old)
S-99383	Late childhood (ages 5-11 years old)
S-99384	Adolescent (ages 12-17 years old)
S-99385	18-39 years (restricted to ages 18-20 years old) **or**
S-99391	Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age younger than 1 year old).
S-99392	Early childhood (ages 1-4 years old)
S-99393	Late childhood (ages 5-11 years old)
S-99394	Adolescent (ages 12-17 years old)
S-99395	18-39 years (restricted to ages 18-20 years old)

f. Exception to Periodicity Modifiers

Use with medical screen codes 99381-99385 or 99391-99395 to indicate the reason for an Exception-to-Periodicity.	
23	Unusual Anesthesia
32	Mandated Services
SC	Medically Necessary Service or supply

One of the following modifiers must be used to indicate the practitioner who performed the unclothed physical examination on the medical screen. An FQHC provider must bill at THSteps visits with modifier EP, service provided as part of Medicaid and Early Periodic Screening Diagnosis and Treatment (EPSDT), in addition to one of the following:

Modifier	Description
AM	Physician, Team Member service
SA	Nurse Practitioner rendering service in collaboration with a physician
TD	RN
U7	Physician Assistant services for other than assistant at surgery

B. Medicaid Managed Care Covered Services

Community First STAR Members are entitled to all covered services in the Texas Medicaid Program. PCPs shall provide and arrange for the provision of all covered services.

NOTE: STAR Members do not have to pay a copayment for covered medical services.

Community First is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the STAR Benefit Program as outlined in its agreement with HHSC. Community First must provide Medically Necessary Covered Services to all enrolled Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. Community First may not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member. Community First will provide full coverage for Medically Necessary Covered Services to all Members without regards to the Member's:

- Previous coverage, if any, or the reason for termination of such coverage.
- Health status.
- Confinement in a health care facility.
- For any other reason.

Community First must provide covered services as described in the most recent "Texas Medicaid Provider Procedures Manual," the "THSteps Manual" (a supplement to the "Provider Procedures Manual"), and in all Texas Medicaid Bulletins, which update the "Provider Procedures Manual" except for those services identified as non-capitated services. Covered Services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

1. Non-Capitated Services

Community First provides coordination for the following Non-Medicaid Managed Care Covered Services (Non-capitated services)

- THSteps Dental (including orthodontia)
- THSteps Environmental Lead Investigation (ELI)
- Early Childhood Intervention (ECI) targeted case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Department of State Health Services (DSHS) Targeted Case Management
- DSHS Mental Health Rehabilitation
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by Department of State Health Services DSHS-approved providers (directly observed therapy and contact investigation)
- Department of Aging and Disability (DADS) hospice services
- Court-ordered commitments to inpatient mental health facilities as a condition of probation
- THSteps Personal Care Services for Members birth through age 20
- DADS LTSS-contracted providers for individuals who have intellectual or developmental disabilities
- DADS contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities

2. Prescribed Pediatric Extended Care Centers (PPECC) and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition, or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code § 363.209(c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

3. 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 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	STAR	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

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage and billing
			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.

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

Community First reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Community First also reimburses for items typically covered under the THSteps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

Please consult the "Texas Medicaid Provider Procedures Manual" (Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections) in addition to this Community First Provider Manual for information regarding the scope of coverage of durable medical equipment and other products commonly found in a pharmacy. See **(Exhibit 25)** for the "Health Home Services (Title XIX) DME/Medical Supplies Physician Order Form**."** Community First encourages your pharmacy's participation in providing these items to Medicaid clients.

Call Community First Member Services **at 210-358-6060** or **1-800-434-2347** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must submit a claim for reimbursement:

Paper Claims

Community First Health Plans, Inc.

P.O. Box 240969
Apple Valley, MN 55124

Electronic Claims

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 at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First's Payor Identification as indicated below:

EDI Electronic Data Interface

- Availity Payor ID: COMMF
- Availity Receiver Type: F

Provider Portal Electronic Billing

- ClaimMD
- Availity

Cancellation of Product Orders

A Provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Member or the Member's authorized representative submits an oral or written request. The Provider must maintain records documenting the request.

Call **210-358-6050** or 1-**800-434-2347** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

5. Dental Services

a. Emergency Dental Services

Community First is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. Community First will pay for devices for craniofacial anomalies, hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

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

b. Non-Emergency Dental Services

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

Community First is **responsible** for paying for treatment and devices for craniofacial anomalies and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a THSteps medical checkup for Members six through 35 months of age.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a main dental home choice.

- OEFV is billed by THSteps Providers on the same day as the THSteps medical checkup.
- OEFV must be billed concurrently with a THSteps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- THSteps providers must assist Members with establishing a main dental home (see Attachment D) and document Member's main dental home choice in the Members' file.

c. Intermediate Oral Evaluation with Fluoride Varnish Application

An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients who are six through 35 months of age.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup visit and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and current diagnosis code per THSteps reference guide Z00129 (routine child exam) and Z00121 (routine child exam abnormal).

An intermediate oral evaluation with fluoride varnish application is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by DSHS Oral Health Program to perform an intermediate oral evaluation with application of fluoride varnish. Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com. The intermediate oral evaluation with fluoride varnish application add-on includes the following components:

- Intermediate oral evaluation
- Fluoride varnish application
- Dental anticipatory guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy

C. Coordination with Non-Medicaid Managed Care Covered Services (Non-Capitated Services)

Community First will make a good faith effort to coordinate services for Non-Medicaid Managed Care Covered Services by subcontracting for these services as appropriate, entering into Memorandums of Understanding (MOU) or direct contracts with providers/agencies that provide these services. The Member's PCP will be responsible for the appropriate coordination and referral of Members for these services. Community First is not responsible for the payment of dental services.

Medicaid dental services are described under 25 Tex. Admin. Code § 33.70-33.72 and at the Secretary of State's website www.sos.state.tx.us.

Dental Services: Dental services for STAR Members are covered from birth through the age of 20 years under the THSteps. Children should have their first dental checkup at six months of age and every six 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 six months can receive dental services on an emergency basis.

Members may contact:

- United Healthcare Dental **877-901-7321**
- DentaQuest **1-800-516-0165**
- MCNA Dental **1-855-691-6262**

D. Texas Agency Administered Programs and Case Management Services

Pharmacy Program

Community First covers prescription medications. Community First 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. Ask your patient about non-prescription medicine or vitamin or herbal supplements they may be taking.

Texas Medicaid Preferred Drug List

You can find out if a medication is on the Texas Medicaid Preferred Drug List. Many preferred drugs are available without prior authorization (PA). Review the list of covered drugs at:

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

The Texas Medicaid 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 on a Palm or Pocket PC handheld device.

Formulary Drug List

The Texas Drug Code Formulary (www.txvendordrug.com/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, prior authorization may be required.

If you want to request a drug to be added to the formulary, please contact HHSC at contact@hhsc.state.tx.us using the 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. Review the list of covered drugs at www.txvendordrug.com/formulary.

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

Mail Order Form for Members

Members may be able to have their medications delivered to them through the mail. Community First's partner for pharmacy benefits is Navitus. Their mail order partner is H-E-B. Please have them call Member Services at 1-800-434-2347 to confirm their pharmacy offers medication delivery by mail.

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 our website at CommunityFirstMedicaid.com

Medicaid STAR 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.

Brand 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 Health Plans. Navitus processes Texas Medicaid pharmacy prior authorization for Community First.

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 "Providers" section or request they be faxed by Customer Care to the

Prescriber's office. Prescribers will need to enter their NPI and select their state from the dropdown menu in order to access the portal.

Completed PA forms can be faxed 24/7 to Navitus at **855-668-8553.** Prescribers can also call Navitus Customer Care at **877-908-6023** to speak with the Prior Authorization department between 8:00 a.m. and 5:00 pm Monday through Friday (CST) to submit a PA request over the phone. After hours, Providers will have the option to leave voicemail.

Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The Provider will either be notified of the outcome by fax, or verbally, if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the criteria are met. If all criteria are met, the claim is approved and paid, and the pharmacy continues with the dispending process. If the automated review determines that all criteria are not met, the claim will be rejected, and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

When a prior authorization 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's Department at **608-729-1577** for review.

Providers may initiate prior authorization through the Provider Portal or via fax at **210-358-6040.**

Note: If the prior authorization request comes back "PA Not Required," it means that the medication does not require prior authorization. However, "PA Not Required" **does not** mean that service is covered. Please contact Member Services at **210-358-6060** should you have questions regarding covered services.

E. 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
- THSteps Medical Checkups
- Prenatal services

School Health and Related Services (SHARS)

School Health and Related Services (SHARS) is a Medicaid service and a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts or shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services included in the student's Individualized Education Program (IEP). Using existing state and local special education allocations as the state match, SHARS providers are reimbursed the federal share of the payment when services are provided to students who meet all of the following requirements:

- Medicaid eligible and under 21 years of age.
- Meet eligibility requirements for special education described in the Individuals with Disabilities Education Act (IDEA).
- Have IEPs that prescribe the needed services.

Current SHARS services include

- Assessment
- Audiology
- Counseling
- School Health Services
- Medical Services
- Occupational, Physical, and Speech Therapy
- Psychological Services
- Special Transportation

These services must be provided by qualified professionals under contract or employed by the school district/shared services arrangements. Furthermore, the

school district/shared services arrangements must be enrolled as a SHARS Medicaid provider in order to bill Medicaid for these services.

1. Early Childhood Intervention

Community First coordinates and cooperates with Early Childhood Intervention (ECI) programs. ECI serves children under the age of three who have disabilities or developmental delays. ECI teaches families how to help their children reach their potential through education and therapy services.

The Provider must cooperate and coordinate with local ECI programs in order to comply with federal and state requirements relating to the development, review, and evaluation of Individual Family Service Plans (IFSP). The Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope, and setting established in the IFSP. If the family or a Provider identifies a child under the age of three to be at risk for having disabilities and/or developmental delays, they must refer the STAR Member to ECI within two working days.

The Provider does not have to give a diagnosis to refer the STAR Member for ECI services. ECI will conduct developmental screenings, assess the child for developmental delay, and determine if the STAR Member is eligible to receive ECI services.

Developmental delays are defined as any significant delays in any of the following areas:

- Cognitive
- Language or speech
- Self-help skills
- Gross or fine motor skills
- Social or emotional

Once the child is enrolled, a plan will be developed to outline the services needed. ECI provides services at the child's home and in a community setting. If the child is not eligible for ECI, the staff will refer the family to other resources.

ECI services may include:

- Assistive Technology
- Audiology
- Early Identification, Screening & Assessment

- Family Counseling
- Family Education
- Home Visits
- Health
- Medical (diagnostic or evaluation services only)
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Psychological
- Service Coordination
- Social Work
- Speech Instruction
- Speech-Language Pathology
- Specialized Skills Training
- Transportation
- Vision

Primary referral sources include:

- Hospitals, including prenatal and postnatal care facilities
- Physicians
- Parents
- Day care programs
- Local educational agencies
- Public health facilities
- Other social service agencies
- Other health care providers

To refer a STAR Member to an ECI program, Providers can call the ECI Care Line at **877-787-8999** or visit https://hhs.texas.gov/services/disability/early-childhood-intervention-services

NOTE: Community First does not require contracted Providers to obtain preauthorization for ECI services. Community First does require a copy of the current ECI Individual Family Service Plan (IFSP) as well as a copy of the transition plan which is created in advance of the child aging out of ECI eligibility. These documents allow Community First to ensure that the ongoing needs of the child are addressed and to facilitate continuity of care.

2. Mental Health Targeted Case Management

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

- Service coordination for adults or children with mental retardation or related condition.
- Case Management for children with serious emotional disturbance (ages 3–17 years).
- Case Management Services for adults with severe and persistent mental illness (age 18 years or older).
- Individual Community Support Services Service Coordination for adults or children with mental retardation or related condition.
- Routine Case Management for adults (age 18 years or older).

A 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 &	T1017	TG and HA	32 units (8 hours) per calendar day for people less than 18 years of age.

Service	Proc Code	Modifier	Limitation
Adolescent)			

Mental Health Rehabilitation

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	H0034	HA and	8 units (2 hours) per calendar day, in any

Service	Proc Code	Modifier	Limitations
Support, Child & Adolescent, with other, individual		HQ	combination, for people less than 18 years of age
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 Rehabilitative Services	H2017	HK and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of

Service	Proc Code	Modifier	Limitations
ACT or ACT alternative consumer, by RN, individual			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

3. 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.

Eligibility for CPW: Any Medicaid 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.

Additional information on the CPW program can be found at www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women

4. Texas Commission for the Blind Case Management

Texas Commission for the Blind Case Management is 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.

Resource categories include:

- 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) 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. They can:

- Assist child in developing the confidence and competence needed to be an active part of their community.

- Provide support and training to parent in understanding your rights and responsibilities throughout the educational process.
- Assist parent and child in the vocational discovery and development process
- Provide training in areas like food preparation, money management, recreational activities, and grooming.
- Supply 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 Services program or to assist a Member to apply for services, visit https://hhs.texas.gov/services/disability/blind-visually-impaired or call **1-877-787-8999**.

5. Tuberculosis 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 **(Exhibit 7**) for reporting TB adopted by DSHS.

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

6. 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 working day**. All other conditions must be reported to the local health department or DSHS **within one 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 **800-252-8239** or **512-458-7111**. By calling **512-458-7111** after hours, you will reach the physician/epidemiologist on-call.

7. 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
P.O. Box 149347
Austin, TX 78714-9347

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

8. Women, Infants, and Children (WIC) Program

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.

Eligibility Requirements

- **Meet the income guidelines.** Households with incomes at or below 185 percent of the federal poverty income level are eligible. 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. To view income eligibility guidelines, visit www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/wic/policy/cs-12-0.pdf.

- **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 the best start for their baby and how to breastfeed while still working.

Information on how to apply for WIC can be found by calling toll-free **1-800-942-3678**.

9. HHSC Hospice Services

HHSC manages the HHSC 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).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six 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 clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued a Texas Benefits Medicaid Card with "HOSPICE" printed on it. Clients 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, visit
https://hhs.texas.gov/services/health/palliative-care/hospice-care

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

Non-hospice providers may be reimbursed directly by TMHP for services rendered to a Medicaid hospice client. Mail paper claims to the following address:

Texas Medicaid & 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.

10. 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 Medicaid providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC website at www.dshs.texas.gov/texas-vaccines-children-texas

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.

F. Non-Emergency Medical Transportation (NEMT) Services

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provides transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.

• Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
• Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the Member and $25 per day for an approved attendant.
• Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
• Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Community First Health Plans at 1-888-444-0307 for more information.

G. Family Planning Services

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

Access to Services. STAR Members may select any Texas Medicaid 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 Medicaid 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 STAR

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 female Members, but should be specific for males.

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 an IUD is inserted.
- 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 STAR Member, per Provider. The Provider may repeat the visit no more than once per state fiscal year, per Provider. An initial STAR Member Education visit may be billed in conjunction with an annual or follow-up visit.

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

The Provider may alter the following initial STAR Member education, according to the educator's evaluation of the STAR 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 STAR Member information about the contraceptive chosen by the 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 if the STAR 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 STAR 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. STAR Members who become pregnant (assessment reveals potential pregnancy) must be provided preconception counseling regarding the modification and reduction of that risk.

If a STAR 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 encounter provides an overview of family planning services available to the STAR 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.
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 Medicaid 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 STAR 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 STAR Member out of the Provider's office for laboratory services, the Provider must direct the STAR 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 STAR 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" 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 STAR Member's PCP and the STAR Member presents with a "medical condition," the family planning provider must refer the STAR Member to their PCP for the appropriate treatment and/or referral for specialty services.

H. Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is covered on an outpatient basis by a psychiatrist or PCP if medication is required. ADHD is treated in individual and family therapy. 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 pre-authorization with a participating provider.

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

I. Access to Telemedicine, Telemonitoring, and Telehealth

STAR 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 GOV'T § 531.0217.

Access to School-Based Telemedicine Services
As required by GOV'T § 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 physician or the 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 GOV'T § 531.0217(c-4).

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

IV. BEHAVIORAL HEALTH

A. 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 STAR Member would present an immediate danger to themselves or others or which renders the STAR 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.

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

- 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.

B. Provider Requirements

- Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for Members between the ages of 0-18 years of age and the Adult Needs and Strength Assessment (ANSA) for Members ages 19 and 20.

- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

- Attestation from provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Member with the full array of MHR and TCM services as outlined in the RRUMG.

- HHSC-established qualification and supervisory protocols.

- Case Management for Children and Pregnant Women (CPW)
    - Submit application to HHSC
    - Obtain approval letter
    - Complete HHSC Case Management Training
    - Obtain appropriate NPI from CMS

C. Behavioral Health Covered Services

- 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
- Authorized inpatient hospital services including services provided in freestanding psychiatric facilities
- Case Management for Children and Pregnant Women (CPW)

D. PCP Requirements for Behavioral Health

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 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.

E. Behavioral Health Services

Member Access to Behavioral Health Services

A STAR Member can access behavioral health services by:

- Self-referral to any network behavioral health provider.
- Calling Community First at **210-358-6100** or **800-434-2347** and obtaining the names of network behavioral health providers.

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

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

- Initial/concurrent review of Members admitted to the hospital or receiving services to determine coverage.
- Assistance obtaining information and checking eligibility.
- Provision of 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.**

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, 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 STAR 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 STAR 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 STAR 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 STAR Member for behavioral health services, Providers must use the 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 STAR Member's medical record.

All network PCPs must ensure all STAR 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 STAR Member, or a parent or legal guardian of the STAR Member, before the Provider can send the STAR Member's Behavioral Health Report to the PCP. The STAR Member will be advised that he/she is not required to sign the release and treatment will not be denied if the STAR Member objects to signing the form. The Provider will place a copy of the signed release in the STAR Member's record.

Court-Ordered Commitments. Community First must provide inpatient psychiatric services to STAR Members under the age of 21 whom the court of competent jurisdiction has ordered to receive the services under the provision of Tex. Health & Safety Code Chapters 573 and 574, 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 STAR Members under age 21. Any modification or termination of court ordered services for STAR Members must be presented to the court with jurisdiction over the matter to make a determination.

A STAR Member who has been ordered to receive treatment under the provisions of Tex. Health & Safety Code Chapters 573 and 574 **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 STAR Members qualify for target case management or rehabilitation services through the Local Mental Health Authority (LMHA), may refer the Member to the nearest LMHA office. The LMHA will assess the STAR Member to determine if they meet criteria for Severe and Persistent

Emotional Disturbance (SPMI) or Severe Emotional Disturbance (SED). Contact Community First at **210-358-6100** for a list of LMHAs in your area.

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

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.

Community First will provide or arrange for training for network PCPs on how to screen and identify behavioral health disorders, 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 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 STAR Members in a behavioral health medical record audit.

Procedure to Follow Up on Missed Appointments. Community First requires that all Providers contact STAR Members if they miss a scheduled appointment to reschedule such appointment within 24 hours of the missed appointment.

Discharge Planning and Aftercare. Providers must notify a Community First Case Manager when they discharge a STAR Member from an inpatient, residential treatment, partial hospitalization, or intensive outpatient setting. STAR 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 days from the date

of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments.

F. Summary Reports to Primary Care Providers

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

G. Emergency Behavioral Health Services

Emergency behavioral health conditions include Emergency Detentions as defined under Tex. Health & Safety Code § 573.0001-573.026 and under Tex. Health & Safety Code § 462.001-462.081.

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 9-1-1 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 toward 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 hours of initial contact, then the Member should be referred to the ED.

V. 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, is developed as an outgrowth of the evaluation of the previous years' quality improvement activities, organizational priorities, and program requirements and 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.

A. 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 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.

B. 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 approved practice guidelines for both Asthma and Diabetes, and they 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.

Providers must cooperate with the organization's QI activities to improve the quality of care and services and Member experience.

The success of the QIP depends upon the Provider's cooperation by:

- Providing medical records concerning Community First STAR Members upon request.
- Maintaining the confidentiality of STAR Member information.
- Promptly responding to our phone calls or letters concerning Quality Management issues.
- Collecting and evaluating data and participating in our Quality Improvement programs
- 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 Network Management Representative.

Community First may use practitioner performance data for quality improvement activities.

C. 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 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 the 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.

D. 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

VI. PROVIDER RESPONSIBILITIES

A. PCP (Medical Home) Responsibilities

PCPs function as the medical home for Community First STAR Members.

Primary Care Provider (or 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.

Health 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 Medicaid the medical assistance program.

To participate in the Medicaid Program, a Provider, with an agreement with HHSC or its agent, must have a Texas Provider Identification Number (TPIN). Medicaid 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 Health Home - PCP Responsibilities. Medicaid health 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 Health Homes. Medicaid health 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 health home services and Provider qualification as they see fit, effective integration of physical and behavioral health services is a critical aspect of program design.

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 STAR Members for the following services:

- CPW Case Management Services
- ECI Case Management Services
- MR Targeted Case Management
- SHARS
- Texas Commission for the Blind Case Management Services
- THSteps Medical Case Management
- THSteps Dental (including orthodontics)
- Tuberculosis services
- Community First's pharmacy program through Navitus

B. Availability and Accessibility

Network PCPs must be accessible to STAR 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:

1. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and which can

contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

2. 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.

3. 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:

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

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

3. 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.

Access Standards

Appointment Type	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) Routine/scheduled inpatient/outpatient care	Within 14 days of request Within 14 days of request 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 termination will be addressed as urgent care.
High-risk pregnancies or new Members in the third trimester	Within five (5) days or immediately if an emergency exists.
Well-child care Well-adolescent care	Routine well-child care: within 14 days of request Routine well-adolescent care: within 14 days of request
THSteps medical checkups	Within 14 days of request
Traveling farm workers' children	Staff must ensure prompt delivery of services to children of traveling farm workers and other migrant populations who may transition into or

Appointment Type	Appointment Availability
	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 US Preventive Service Task Force recommendations
Physical Therapy	Within 24 hours (urgent) 3 days or less (routine) 14 days or less (follow-up)
Radiology	Within 24 hours (urgent) 7 days or less (MRI/CT Scan) 10 days or less (IVP/UGI) 21 days or less (Mammogram)
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within two (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 four (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

C. 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 STAR 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 INS § 843.306 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:

1. Imminent harm to patient health.
2. 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.
3. 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 INS § 843.306, 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.

D. Member’s Right to Designate an OB/GYN

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

STAR dual-eligible Members are excluded from this provision.

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

E. Advance Directives

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

It’s the Members right to accept or refuse medical care. 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**.

F. Referral to Specialists and Health-Related Services

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

G. PCP & Behavioral Health 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 training and/or practice. STAR dual-eligible Members are excluded.

H. 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 Network Management Department at **210-358-6030** 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 STAR Members under age 21, however, the HMO will not 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**.

I. Access to a Second Opinion

Members have access to 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.

J. Specialty Care Provider Responsibilities

Availability and Accessibility. Network specialists must be accessible to STAR 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:

1. 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.

2. 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.

3. 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:

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

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

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

Members with disabilities, special health care needs, and chronic or complex conditions are allowed to have direct access to a specialist. The network specialist must agree to perform all PCP duties, and such duties must be within the scope of the participating specialist's certification. Please refer to the Introduction, Section C of this Provider Manual for further information.

Access Standards:

Appointment Type	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

Appointment Type	Appointment Availability
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) Routine/scheduled inpatient/outpatient care	Within 14 days of request Within 14 days of request 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 termination will be addressed as urgent care.
High-risk pregnancies or new Members in the third trimester	Within five (5) days or immediately if an emergency exists.
Well-child care Well-adolescent care	Routine well-child care: within 14 days of request Routine well-adolescent care: within 14 days of request
THSteps medical checkups	Within 14 days of request
Traveling farm workers' children	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

Appointment Type	Appointment Availability
	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 US Preventive Service Task Force recommendations
Physical Therapy	Within 24 hours (urgent) 3 days or less (routine) 14 days or less (follow-up)
Radiology	Within 24 hours (urgent) 7 days or less (MRI/CT Scan) 10 days or less (IVP/UGI) 21 days or less (Mammogram)
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within two (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 four (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

K. Verify Member Eligibility and/or Authorization for Services

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

Each STAR Member is issued a Your Texas Benefits Medicaid Card **(Exhibit 2)** and a Plan (i.e., Community First) ID Card. We instruct the STAR Member to present both ID cards when requesting services. The Community First ID Card **s**hows important Member information and important Community First telephone numbers.

At the time of the visit, ask the Member to show both forms of ID. The Your Texas Benefits Medicaid Card will verify coverage for the current month only, identify if the cardholder is a STAR Member, and state the name of the plan. The Community First ID card and Medicaid ID forms do not guarantee eligibility for coverage. To verify eligibility, sign in to Community First Health Plan's Provider Portal at cfhpprovider.healthtrioconnect.com or call Member Services Department at **210-358-6403.** Eligibility may also be obtained through TMHP's Automated Inquiry System (AIS) or TMHP's Electronic Data Interchange (EDI). If conflicting PCP information is found, please contact Community First Member Services Department for assistance. Providers must document this verification in their records and treat the client as usual.

PCP information is not shown on the Texas Benefits Medicaid Card and is only printed on the Community First's ID card. Listed below are helpful ways to verify eligibility:

- Call Community First Member Services at **210-358-6060** or toll-free **1-800-434-2347**
- Log in to the Community First Provider Portal
- Review the temporary ID (Form 1027A), which is issued when the Member's Texas Benefits Medicaid Card is lost or stolen, or temporary emergency Medicaid is granted
- Call AIS Line at **512-345-5949** or **1-800-925-9126**

If a Member has questions about benefit coverage or wants to change to a different PCP, please ask him or her to call our Member Services Department at **210-358-6403**. Community First will arrange for all covered services for the period STAR 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.

- **Inpatients after enrollment with Community First.** Community First is responsible for services until they discharge the STAR Member from the hospital, unless the STAR Member loses Medicaid or STAR eligibility.

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

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

- **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 STAR 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 STAR Members under age 21, 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 Referral Notification section in this Provider Manual).

Community First currently requires preauthorization for services listed on the authorization list at CommunityFirstMedicaid.com/prior-authorizations.

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: Pre-authorizations 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 STAR 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 Form for Health Care Services" **(Exhibit 6)** to **210-358-6040.**

- Submit secure electronic requests using Community First online medical management portal. (Contact Community First's Network Management Department at **210-358-6030** or email nmcfhp@cfhp.com for access.)

The Population Health Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. (CST), Monday through Friday. 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 pre-authorization:

- 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)

The Population Health Management Department 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 being approved.

If a request is pended 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 services 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 STAR Member is 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. The appeal information will be on the denial letter.

L. Continuity of Care

For Pregnant Women. Continuity of care for pregnant Members with 12 weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery. The Member 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 using the "Request for Continuity/Transition of Care Form" **(Exhibit 1).**

For a Member that Moves Out-of-Area. Community First will reimburse out-of-network providers for covered services rendered to STAR 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 by fax to Community First's Population Health Management Department at **210-358-6040** or requested by phone at **210-358-6050.**

For Pre-existing Conditions. Community First is responsible for arranging for the provision of all covered STAR services to each eligible Community First STAR Member beginning on the STAR 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 STAR services will be in accordance with contractual requirements between Community First and the Provider.

M. Transition and Continuity of Care

Community First will ensure that the care of newly enrolled Community First STAR Members is not unreasonably disrupted or interrupted to the magnitude that the STAR Member's health could be placed in jeopardy if such care is disrupted or interrupted. Community First provides STAR 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 Case Managers, STAR Members with medical or behavioral disabilities or chronic/complex conditions are encouraged to maintain a stable "medical home."

Continuity of care. Care provided to a STAR Member by the same primary care provider or specialty provider to the greatest degree possible, so that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

PCPs and specialists can call the Population Health Management Department at **210-358-6050** to address any continuity/transition of care issues or fax the "Request for Continuity/Transition of Care" form **(Exhibit 1)** to **210-358-6040.**

N. 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 Medicaid regarding 1997 CMS documentation and coding guidelines; the National Correct Coding Initiative; Global Surgical Period; Physician Signature Guidelines; and current American Medical Association (AMA) Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10). The Texas Medicaid Provider Procedures Manual also recognizes guidelines from the Centers for Medicare and Medicaid 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 guidelines for the amendment of medical records as outlined in 22 Tex. Admin. Code § 165.1.

- 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 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.

O. Justification for Out-of-Network Authorizations

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

1. 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:

- Medicaid covered services are medically necessary and these services are not available through a 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.

2. 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.

3. 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.

4. 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 1 Tex. Admin. Code, Part 15, Chapter 355:

- For a date of service on or after 02/20/2010, out-of-network/in-area providers were reimbursed at Medicaid minus 5 percent in accordance with the change in 1 Tex. Admin. Code, Part 15, Chapter 355.

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

P. Community First Choice

Program Provider Responsibilities
The Community First Choice (CFC) services must be delivered in accordance with the Member's service plan. The program provider must have current documentation which includes the Member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).

The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).

The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure

the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.

The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation.

The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation; and the DFPS hotline **1-800-647-7418**.

The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.

The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.

The program provider must ensure that the service providers meet all the personnel requirements (e.g., age; high school diploma/GED or competency exam; three references from non-relatives; current Texas driver's license and insurance if transporting; criminal history check; employee misconduct registry check; nurse aide registry check; OIG checks).

For CFC ERS, the program provider must have the appropriate licensure to deliver the service.

Per 42 C.F.R. § 441.565, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.

The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.

The program provider must adhere to Community First's financial accountability standards.

The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.

The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Q. 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.

R. Access to Medication

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

S. 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 a card from their dental plan, the Member can contact the Medicaid enrollment broker's toll-free telephone number at **1-800-964-2777**.

T. Fraud, Waste, and Abuse

The Provider understands and agrees to the following:

1. HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Providers and their employees, agents, health plans, and patients.

2. Requests for information from such entities must be complied with, in the form and language requested.

3. Providers and their employees, agents, and health plans must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense.

4. Compliance with these requirements will be at the Provider's expense.

5. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid Programs, as applicable.

6. Providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, waste or abuse.

7. Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free of charge.

8. If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and

9. Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by Community First or a Member to the HHSC Office of Inspector General.

If the Provider receives annual Medicaid 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.

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

U. 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 the 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.

V. 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.

W. Provider Network Requirements

Under Medicaid agreements, the TPI and NPI for acute care providers serving Medicaid members must enter into and maintain a Medicaid provider agreement

with HHSC or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). All Medicaid providers must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

X. Credentialing and Re-credentialing

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 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 & procedures
- An office site review and evaluation
- A medical record audit

Advance Nurse Practitioner Requirements. To be a provider of Medicaid 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 Medicaid 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.

These policies and procedures 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 1 Tex. Admin Code § 354.1251 (relating to Nurse-Midwife services) and 1 Tex. Admin Code §354.1301 (relating to 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 has 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

You can refer to the "Medical Record Review Tool" **(Exhibit 12)** and the "Preventive Services for Adults" **(Exhibit 14)** 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.

Y. 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.

Z. 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 this Provider Manual)
11. Closed or Open Panel (PCPs only)
12. THSteps 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.

AA. 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:

- Report any confirmed or suspected cases of abuse and neglect to DFPS.
- Provide medical records at the time the records are requested.

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

The Provider 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.

- Recognizing abuse and neglect and appropriate referral to DFPS.

VII. ROUTINE, URGENT AND EMERGENCY SERVICES

A. Definitions

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 STAR Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in:

- Placing the STAR 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, STAR 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 STAR 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 STAR 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 STAR Member needs to be transferred to another facility and the medical condition of the STAR 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 STAR Member must contact his or her PCP to arrange any non-emergency care needed. If the STAR Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the STAR 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 STAR Member's PCP or PCP designee to prevent serious deterioration of the STAR 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 has arrangements with Urgent Care Clinics listed in the Provider Directory. In addition, we offer a 24/7 Nurse Advice Line at **210-358-3000** or toll-free **at 1-800-434-2347** staffed by registered nurses who provide advice according to written protocols and assist STAR Members in accessing treatment.

Community First Members can also get in-home, same-day urgent medical care through DispatchHealth. Request an appointment by calling 210-981-5366 or visit Request.DispatchHealth.com.

Services provided at the Urgent Care Clinics are limited to:

- **After-hours Urgent Care**

Weekdays/Weekends & Holidays	5:30 p.m. - 8:30 a.m.
Day Preceding a Holiday	After 5:00 p.m.

Day Following a Holiday	Before 8:30 a.m.

- **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 PCPs nursing staff should triage the patient or refer to the Nurse Advice Line if the PCPs nursing staff is unavailable.

- **Requirements for Scheduling Appointments/Referrals to the Urgent Care Clinic.** When referring a STAR Member to an Urgent Care Clinic, the PCP or PCP's nursing staff should call the clinic and notify the clinic they are referring the patient. If a STAR Member goes to one of the clinics without approval, the clinic must contact the PCP. If the PCP does not respond within a reasonable length of time, depending on the medical situation, the clinic should call Community First's Population Health Management Department or the Nurse Advice Line.

If the examining physician determines that a **true medical emergency exists**, the STAR 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 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.

B. Emergency Transportation

According to 1 Tex. Admin. Code § 354.1111, an emergency transport is a service provided by a Medicaid-enrolled ambulance Provider for a Medicaid client 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.

C. Non-Emergency Transportation Services

Non-Emergency Medical Transportation (NEMT) services are available to eligible Medicaid clients who have no other means of transportation. These services are detailed in the "Non-Emergency Medical Transportation" section of this Provider Manual.

In addition, as a value-added service, Community First can provide extra help getting a ride for medical and behavioral visits, Community First sponsored events, health classes, and Member Advisory Group meetings.

D. Member/Client Acknowledgment Statement

A Provider may not bill a STAR 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 STAR 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" signed by the patient and the Provider **(Exhibit 13)**.

The Provider must obtain and keep a written "Member/Client Acknowledgment Statement" signed by the client that states:

"I understand that, in the opinion of (Provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and

receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cobra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determinan la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

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

- Any service that is not a benefit of the Texas Medicaid 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. Spell of illness limitations do not apply to medically necessary stays for THSteps-eligible clients younger than age 21 years.

- 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.

E. Private Pay Form Agreement

A Participating physician and/or provider may bill a STAR Member only if:

- A specific service or item is provided at the STAR Member's request.

- The Provider has obtained and kept a written "Private Pay Agreement" signed by the client. **(Exhibit 18)**.

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 STAR Member. Without written, signed documentation that the STAR Member was properly notified of the private pay status, PCP and/or participating provider cannot seek payment from an eligible STAR Member.

If the Member is accepted as a private pay patient pending Medicaid eligibility determination and the Member does **not** become eligible for Medicaid 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 Medicaid Program and termination from network participation with Community First.

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

F. 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, 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 take the following actions contact Navitus Health Solutions Provider Hotline at **1-877-908-6023.**

G. Emergency and Non-Emergency Dental Services

Emergency and non-emergency dental services are available to eligible Medicaid clients. Services are outlined in the "Covered Services" section of this Provider Manual.

H. Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Durable Medical Equipment is available to eligible Medicaid clients and are outlined in the "Covered Services" section of this Provider Manual.

VIII. PROVIDER COMPLAINTS/APPEALS PROCESS

A. 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 **210-358-6030** or **1-800-434-2347.**
- Online, by emailing nmcfhp@cfhp.com(via secure/encrypted email) or through Community First secure Provider portal (click the "Contact Us" link).
- By faxing Community First's Network Management Department to **210-358-6199.** (Please include fax cover sheet along with Provider complaint form).

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, the Network Management Department will send a letter acknowledging receipt of the complaint within five (5) working days from the date of receipt. If the Provider complaint is received orally, the Network Management Department will send a "Provider Complaint" form with (**Exhibit 20**). The Provider must complete and return the form to Community First for prompt resolution of the complaint. Once the "Provider Complaint" form is received by Community First, a letter will be sent acknowledging receipt of the complaint within five (5) working days from the date of receipt.

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

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 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.

B. 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 STAR Member are not medically necessary, you or the Member may appeal orally, followed up with a written appeal.

- Members: Orally **210-358-6060** or **1-800-434-2347**
- Providers: Orally **210-358-6030** or **1-800-434-2347**
- Fax number **210-358-6199** (Please include appeal form)
- Online: Community First secure Provider Portal (click the "Contact Us" link)

Retain the following documentation:

- Fax cover pages
- Emails to and from Community First
- A log of telephone communication

Provider Appeals Process

1. 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.

2. 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.

3. 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.** A clear and concise statement of the specific medical or contractual reason for the resolution.
- **b.** The clinical basis for such decision.
- **c.** The specialty of any physician or other provider consultant.
- **d.** If the appeal is denied, the written notification will include notice of the appealing party's right to seek a State Fair Hearing (See Member Complaints and Appeals section).

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

C. Provider Complaint Process to HHSC

A Provider, who believes they did not receive full due process from Community First, may file a complaint with HHSC. HHSC is only responsible for the management of complaints. Appeal, hearing, or dispute resolutions are the responsibility of Community First. Providers must exhaust the appeals/complaint process with Community First before filing a complaint with HHSC.

Complaints must be received by HHSC. Providers should refer to the Texas Medicaid Provider Manual for specific information on complaint requirements.

The Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

You can also file a complaint with HHSC by email to HPM_Complaints@hhsc.state.tx.us

D. Provider Appeal Process to HHSC (Related to Claim Recoupment Due to Member Disenrollment)

Upon notification of a claim payment recoupment, the first step is for the Provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. Member eligibility was changed to Fee-for-Service on the date of service.

The Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the Provider is requesting an Exception Request.
- **The Explanation of Payment (EOP) showing the original payment.** This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOP showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOP.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. In cases where issuance of a prior authorization (PA) is needed, the Provider will be contacted with the authorization number and will need to submit a corrected claim that contains the valid authorization number.

NOTE: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

Mail Fee-for-Service-related appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, TX 78720-4077

Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a Provider appeals prior to submitting the new claims, the Provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date of service. In accordance with 1 TAC $ 354.1003, Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. Member eligibility changed from one Managed Care organization (MCO) to another on the date of service.

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the Provider is requesting an Exception Request.

- **The Explanation of Payment (EOP) showing the original payment.** The EOP showing the recoupment and/or the MCO's "demand" letter for recoupment must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOP.

- **Documentation must identify** the client name, identification number, DOS, recoupment amount, and other claims information.

NOTE: Label the request “Expedited Review Request” at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals to Community First online via the Provider Portal

Mail Fee-for-Service-related appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, TX 78720-4077

IX. MEMBER COMPLAINT/APPEAL PROCESS

A. Member Complaint Process

STAR 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 MCO other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). 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. A complaint 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, Community First is here to help. Please direct them to call Member Services at **210-358-6060** or toll-free at **1-800-434-2347**.

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 a Member is not satisfied with the resolution of the complaint, after they have used the Community First complaint process, they may file a complaint with HHSC by taking one of the following actions:

a. Call Medicaid Managed Care Helpline at **1-866-566-8989** (toll free)
b. Online at https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman
c. Mail to:
   Texas Health and Human Services Commission
   Office of the Ombudsman, MC H-700
   P.O. Box 13247
   Austin, TX 78711-3247
d. Fax: **1-888-780-8099**

HHSC also accepts email complaints at HPM_complaints@hhsc.state.tx.us

B. Member Appeal Process

If Community First denies or limits a request for a covered service, the Member will be notified by mail. The Member will receive a formal letter from Community First explaining the decision.

The Member may than request an appeal. The Member can appeal denial of payment for services in whole or part.

If a Member wishes to appeal, the Member or the Member's authorized representative must file the appeal on or before the later of

- 10 days following Community First's mailing of the notice of the action,
- or the intended effective date of the proposed action, in order to ensure continuity of current authorized services.

Community First Member Services can assist a STAR Member or a Member's authorized representative in filing an appeal. A Member or the Member's authorized representative can call **1-800-434-2347** to request an appeal form or assistance with understanding Community First's appeal process.

Appeals can be made orally or in writing at the address below:

Community First Health Plans
Attn: Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Timeframe of the Appeal Process

The entire standard appeals process must be completed by Community First within 30 days after receipt of the initial written or oral request for appeal. This deadline may be extended for up to 14 days at the request of a Member or if Community First shows that there is a need for additional information and how the delay is in the Member's interest. If Community First needs to extend, the Member must receive written notice of the reason for delay.

Community First will send the Member an acknowledgement of the appeal within five (5) days and a decision on the appeal within 30 days.

The Member may be required to pay cost of services furnished while appeal is pending, if the final decision is adverse to the Member.

External Medical Review and State Fair Hearing

If a Member is not satisfied with the appeal decision, they can request an External Medical Review and State Fair Hearing no later than 120 days after the date Community First Health Plans mails the appeal decision notice.

The Member also has the option to request only a State Fair Hearing Review no later than 120 days after Community First mails the appeal decision notice.

C. Member Expedited Appeal

Community First STAR Members may request an expedited appeal if the STAR Member is not satisfied with the denial covered benefit. Community First STAR 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 a STAR Member who would like to file an expedited appeal.

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 is not to exceed one (1) to three (3) days 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 can show that there is a need for additional information and how the delay is in the Member's interest.

If the Member's request for an Expedited Appeal is denied, the request will then be moved to the regular appeal process. Community First will send the Member written notice of this change by mail within two (2) calendar days.

D. State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

If a Member, as a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member

may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either call 1-800-434-2347 or write a letter to the health plan at the following address:

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

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

E. External Medical Review Information

Can a Member of Community First ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling Community First the name of the person the Member wants to represent him or her. A Provider may be the Member's representative.

The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the "State Fair Hearing and External Medical Review Request Form" provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Community First by using the address or fax number at the top of the form;
- Call Community First at **1-800-434-2347**; or
- Email Community First at gmappeals@cfhp.com.

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person.

An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting Community First at 1-800-434-2347 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Community First.

To qualify for an emergency External Medical Review and emergency State Fair Hearing , the Member must first complete Community First's internal appeals process.

X. MEMBER ELIGIBILITY AND ADDED BENEFITS

A. Eligibility

The Health and Human Services Commission (HHSC) is responsible for determining Member eligibility.

1. Persons Eligible to Participate in the STAR Program:

a. **Mandatory enrollment** in one of the STAR Managed Care programs is required for persons qualifying under TANF and TANF-related guidelines. See "Medicaid Eligibility Verification Form (H 1027-A)" **(Exhibit 22).**

b. **Voluntary enrollment** in one of the STAR Managed Care programs is allowed for persons who are Blind and Disabled and are not Medicare eligible. See "Medicaid Eligibility Verification Form (H 1027-A)" **(Exhibit 22)**

1. Persons Not Eligible to Participate in STAR Managed Care:

a. Persons who are Medicare eligible
b. Nursing Home Residents
c. Aliens and Foster Children
d. Persons in the Medically Needy Program

B. Verifying Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. Having a card, however, does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

NOTE: Members can request a new Your Texas Benefits Medicaid card by calling **1-800-252-8263**. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view THStepsAlerts, and more.

NOTE: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

Each STAR Member is issued a Your Texas Benefits Medicaid and a health plan (i.e., Community First) ID card. Community First instructs STAR Members to present both ID cards when requesting medical services.

The Community First ID Card shows important Member information such as Community First telephone numbers and the Member's assigned PCP. Providers may contact Community First to verify Member eligibility by calling **210-358-6060.**

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

If the Member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services; therefore, the primary care provider's name, address, and telephone number are not listed on the Member's ID card.

At the time of the visit, ask the Member to show both forms of ID. The Texas Benefits Medicaid Card will verify coverage for the current month only, identify if the holder is a STAR Member, and name of the plan. The Community First ID Card and Texas Benefits Medicaid Card do not guarantee eligibility for coverage. Eligibility may also be verified through TMHP's Automated Inquiry System (AIS), TexMedConnect, or the Community First Provider Web Portal.

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call the TMHP Provider helpline at **1-855-827-3747**.
- Call Provider Services at the patient's medical or dental plan.
- Electronic eligibility verification transactions.

The Provider must document verification in their records and treat the client as usual.

NOTE: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling **1-855-827-3748**. Medicaid Members also can go online to order new cards or print temporary cards.

Temporary ID (Form H1027-A):

Form 1027-A is acceptable as evidence of eligibility during the eligibility period of the letter unless the letter contains limitations that effect eligibility for the intended services. Providers must accept either Texas Benefits Medicaid Card or Form 1027-A as valid proof of eligibility. If the Member is not eligible for medical assistance or certain benefits, the Member is treated as a private pay patient.

Although the temporary "Medicaid Eligibility Verification Form (H 1027-A)" **(Exhibit 22)** identifies eligible clients when the client Texas Benefits Medicaid Card is lost or has not yet been issued, Form 1027-A does not indicate periodic eligibility for medical checkup services. Providers should call the TMHP Contact Center at 800-925-9126 or check the TMHP website at www.tmhp.com to verify a client's periodic eligibility for medical checkup services.

NOTE: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility. A copy is required during the appeal process if the client's eligibility becomes an issue.

Provider Access to Medicaid Medical and Dental Health Information. Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for Providers. This portal aggregates data (provided from TMHP) into one central hub – regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through "My Account."
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- THSteps and benefit limitations information.
- A viewable and printable Medicaid Card.
- Display if the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the last dental anesthesia procedure date.

Additionally, an online portal is available to patients at www.YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card.
- See their medical and dental plans.
- See their benefit information.
- See THSteps alerts.

- See broadcast alerts.
- See diagnosis and treatments.
- See vaccines.
- See prescription medicines.
- Choose whether to let Medicaid doctors and staff see their available medical and dental information.

NOTE: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

C. Benefits

Community First must provide covered services as described in the most recent "Texas Medicaid Provider Procedures Manual" ("Provider Procedures Manual"), the "THSteps Manual" (a supplement to the "Provider Procedures Manual"), and in all Texas Medicaid Bulletins, which update the "Provider Procedures Manual" except for those services identified as non-capitated services. Covered services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

In addition to the standard covered benefits, Community First STAR Members are eligible for the following benefits:

- Annual adult well checks
- Removal of the Spell of Illness limitation
- Unlimited prescriptions (Benefit is only available for Members who are not covered by Medicare)
- $200,000 annual limit on inpatient services does not apply for STAR Members

D. Value-Added Services

Community First Network Providers may visit Community First's website CommunityFirstMedicaid.com/value-added-services for a current list of Value-Added Services. STAR Members are informed through the HHSC health plan comparison charts (STAR Value-Added Services). These services also appear in the STAR Member Handbook.

E. Involuntary Disenrollment Process

Community First has a limited right to request disenrollment of STAR Members.

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

- STAR Member misuses or lends his/her Community First ID card to another person to obtain services.

- The STAR Member is disruptive, unruly, threatening or uncooperative to the extent that the STAR Member seriously impairs Community First Health Plan's or a Provider's ability to service the STAR Member. However, this only occurs if the STAR Member's behavior is not due to a physical or behavioral health condition.

- The STAR 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.

IX. MEMBER RIGHTS AND RESPONSIBILITIES

A. Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:

- **a.** Be treated fairly and with respect
- **b.** Know that your medical records and discussions with your Providers will be kept private and confidential

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:

- **a.** Be told how to choose and change your health plan and your primary care provider.
- **b**. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
- **c.** Change your primary care provider.
- **d.** Change your health plan without penalty.
- **e.** Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not
understand. That includes the right to:

- **a.** Have your Provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
- **b.** Be told why care or services were denied and not given

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

- **a.** Work as part of a team with your Provider in deciding what health care is best for you
- **b**. Say yes or no to the care recommended by your Provider

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a

timely response to complaints, appeals, External Medical Review and State Fair Hearings. That includes the right to:

a. Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan
b. Get a timely answer to your complaint
c. Use the plan's appeal process and be told how to use it
d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works
e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get information about how that process works

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need
b. Get medical care in a timely manner
c. Be able to get in and out of a health care Provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act
d. Have interpreters, if needed, during appointments with your Providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your 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.

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

B. Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- **a.** Learn and understand your rights under the Medicaid program.
- **b.** Ask questions if you do not understand your rights.
- **c.** Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

- **a.** Learn and follow your health plan's rules and Medicaid rules.
- **b.** Choose your health plan and a primary care provider quickly.
- **c.** Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
- **d.** Keep your scheduled appointments.
- **e.** Cancel appointments in advance when you cannot keep them.
- **f.** Always contact your primary care provider first for your non-emergency medical needs.
- **g.** Be sure you have approval from your primary care provider before going to a specialist.
- **h.** Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

- **a.** Tell your primary care provider about your health.
- **b.** Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated.
- **c.** Help your Providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

- **a**. Work as a team with your Provider in deciding what health care is best for you.
- **b.** Understand how the things you do can affect your health.

c. Do the best you can to stay healthy.
d. Treat Providers and staff with respect.
e. Talk to your Provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U. S. Department of Health and Human Services (HHS) toll free at **1-800-368-1019**. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

C. Self-Referrals

STAR Members may self-refer for the following services:

- Emergency Care
- Urgent Care
- THSteps Dental
- Family Planning Services
- Obstetrical and/or Gynecological Services
- School Health & Related Service (SHARS)
- MHMR Services
- Behavioral Health
- Case management – Children and Pregnant Women (CPW), Early Childhood Intervention (ECI), THSteps Case Management
- School Based Health Clinics Services
- Additional eye health care services provided by an in-network Optometrist or Ophthalmologist (other than surgery) can be provided without a referral from the Member's Primary Care Provider. Covered surgical/laser care requires prior authorization.

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

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

Community First allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's primary care provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to select an OB/GYN without a referral from their primary care provider. An OB/GYN can give the Member:

- One well-woman checkup per year

- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

E. Fraud Information: Reporting Fraud, Waste, or Abuse by a Provider or Client in Medicaid Managed Care

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

Let Community First 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 fraud, waste or abuse, which is against the law. For example, tell Community First 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 ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

2. To report Fraud, Waste or Abuse, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**
- Visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form
- You can report directly to Community First at:

Community First
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

You can also call Community First Health Plan's toll-free phone number at **1-800-434-2347** or our Fraud Hotline at **210-358-6332 or** submit a referral on Community First's Provider Web Portal.

3. To report Fraud, Waste or Abuse, gather as much information as possible.

When reporting a Provider (a doctor, dentist, counselor), include:

- Name, address, and phone number of the Provider
- Name and address of facility (e.g., hospital, nursing home, home health agency)
- Medicaid number of the Provider and facility (if you have it)
- Type of Provider (e.g., doctor, dentist, therapist, pharmacist)
- Contact information of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting abuse by 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 fraud, waste or abuse

4. Special Investigations Unit

Community First is committed to protecting and preserving the integrity and availability of health care resources to our recipients, our health care partners, and the general community.

Community First performs these activities through its Special Investigation Unit to detect, prevent and eliminate fraud, waste and abuse at the Provider, recipient and health plan level. Community First uses electronic systems and training of our employees, health plans, and agents to identify and report possible acts of fraud, waste and abuse. When such acts are identified, Community First seeks effective remedies to identify overpaid amounts; recover identified amounts, prevent future occurrences of fraud, waste and abuse fraud; and report offenses to the appropriate agencies when necessary.

Special emphasis is placed on defining specific acts of fraud, waste and abuse.

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

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

Acts of **Abuse** are defined as activities that unjustly enrich a person through the receipt of benefit payments.

Community First considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjustly benefit payments are not considered unless there is documented previous education in writing or in person by Community First regarding the same or similar adverse audit findings or there are obvious program violations.

To report Providers, use this address:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

To report clients, use this address:

Office of Inspector General
General Investigations
Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200

5. Procedures for Audit and Investigation:

Audits. Providers agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Provider's contract and any records, books, documents, and papers that are related to the Network Provider contract and/or the Provider's performance of its responsibilities under this contract:

- The United States Department of Health and Human Services or its designee
- The Comptroller General of the United States or its designee
- MCO Program personnel from HHSC or its designee
- The Office of Inspector General
- The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee
- Any independent verification and validation health plan, audit firm, or quality assurance health plan acting on behalf of HHSC
- The Office of the State Auditor of Texas or its designee
- A state or federal law enforcement agency

- A special or general investigating committee of the Texas Legislature or its designee
- Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC

Providers must provide access wherever it maintains such records, books, documents, and papers. Providers must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes:

- Examination
- Audit
- Investigation
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions

The Provider understands and agrees that the acceptance of funds under the said contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost

Community First performs audits to monitor compliance and assist in detecting and identifying possible Medicaid program violations and possible fraud, waste and abuse overpayments through

- **Data matching** – Procedures, treatments, supplies, tests, and other services as well as diagnosis billed are compared for reasonableness using available sources including the American Medical Association (AMA), Centers for Medicare/Medicaid Services. Comparisons include age, gender, and specialty when applicable.

- **Analysis** – Inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of Providers' activities lists outliers based on particular specialty and across all specialties and includes procedures, modifiers, and diagnosis. Pharmacy data may be reviewed if provided in usable format by HHSC.

- **Trending and Statistical Activities** – Community First uses EDI Watch software to build Provider profiles that show trends and patterns of submissions based on key claim elements and includes Providers' patient activities. Statistical analysis shows Provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

Monitoring. Community First monitors patterns for Providers, subhealth plans and facilities submitting claims. The monitor lists outliers based on claims submissions and utilization. Any Provider that is flagged for certain payment patterns is also examined for other flags to paint an overall profile. Recipients with flags will be examined for other flags as well and to evaluate patient-Provider relationships.

Hotline. Community First maintains an anti-fraud hotline, at 210-358-6332 to allow reporting of potential or suspected violations of fraud, waste and abuse by Members, Providers and employees. A recording device is utilized to capture calls. Messages left on the recording device and are answered by Community First personnel within two business days. The hotline number is printed on appropriate Member and Provider communications and published on the Community First web site. The hotline number is also included in Community First Provider and Member handbooks.

Community First maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

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

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

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

Routine Validation. Community First provides our vendor, EDI Watch with three years of claims data. EDI Watch processes the electronic claims data on a quarterly basis. EDI Watch supplies a data load to Community First, which applies edits, flags, fraud rules, and build routine activity profiles. These routine validations produce:

- Summary of Findings – A high level of flags and potential overpayment across all claims to identify major areas of concern.
- Triage Reports – List of Providers that are in the high percentile of flags and/or utilizations on which Community First can focus.
- Detail Reports – Provide details supporting the profile activities of a Provider or patient.

6. Procedures for Detecting Possible Acts of Fraud, Waste, or Abuse by Recipients

Community First employs software flags for detecting possible acts of fraud, waste, or abuse by Community First recipients. Flags include

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

Community First employs Community First specialty codes to identify psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists. The software flags can detect by specialty code possible overuse and/or abuse of psychotropic and/or

controlled medications by recipients who are treated by two or more physicians at least monthly.

Community First requests medical records for the recipients in question if claim data review does not clearly determine evidence of overpayment. Upon the receipt of the records from the Provider, Community First reviews the documentation for appropriateness and reports to the HHSC-OIG if necessary.

7. Procedures for Determining General Overpayments

The following types of reviews are performed in the determination of overpayments:

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

Findings that are considered general overpayments include:

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

8. Reporting and Returning Overpayments

Patient Protection and Affordable Care Act [PPACA § 6402(a)] signed by President Obama on March 23, 2010 requires that Medicaid overpayments be "reported and returned" **within 60 days** after they are "identified." When a Provider has "identified" an overpayment, the Provider has the

responsibility to report and return the overpayment to Community First and notify Community First in writing of the reason for the overpayment.

The failure to timely report and/or return any Medicaid overpayments, identified by either Providers or Community First , can have severe consequences, including termination from the Provider Network, potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs. (PPACA § 6402(d)(2); PPACA § 6502)

Community First will notify Providers of any identified overpayments within 60 calendar days of the findings. Refunds are due within 60 calendar days of the refund request. Refunds not received or appealed in a timely manner may be recouped. Community First may analyze claim data or validate services for improper payments/overpayments up to a maximum of a three (3) year period from the date of the received claim(s). (PPACA § 6411)

Community First has established the following process regarding recovery of overpayments discovered through reviews and audits excluding fraud investigations.

Medicaid program general overpayments will be processed in the following manner:

- Notification of overpayments may occur after the completion of an audit, medical record review, data validation, monitoring activities and/or appeals.
- Be in writing and include the specific claims and amounts for which a recoupment is due.
- Provide the basis and specific reasons for the proposed recoupment.
- Include notice of the physician's or Provider's right to appeal.
- Describe the method and due date by which the recoupment will occur.
- Describe actions that will occur if no appeal is received.

9. Medicaid Program Overpayment Appeal Process

- A physician or Provider may appeal a request for recoupment by providing written notice of disagreement of the refund request not later than 45 days after receipt of overpayment notice. Upon receipt of written notice, Community First shall begin the appeal process as provided in the contract with the physician or Provider.

- A refund will not be recouped until the later of the 45th day after

overpayment notification or Provider has made arrangements in writing for payment with Community First prior to the 45th day overpayment notification.

- The appeal process does not apply in cases of fraud or a material misrepresentation. Fraud is considered and noted as intentional after a practitioner or Provider has been previously educated in writing or in person by Community First regarding the same or similar audit, review or investigational findings or there is reasonable clear evidence of intent.

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

- Recoupment of overpayment from future claims
- Payment hold
- Termination from the Community First Network
- Referral to the appropriate regulatory agency
- Exclusion from Medicare/Medicaid

Failure to respond to a medical records request

Failure to submit medical records as requested will result in recoupment. Additionally, in accordance with 1 Tex. Admin. Code §§ 371.1617(2), 371.1643, and 371.1649 sanctions may be imposed against you if you fail to provide the information as requested. Possible sanction actions may include, but not limited to, vendor hold and/or exclusion from participation as a Provider in the Texas Medicaid program, until the matter is resolved. Additionally, payments for services for which records are not produced may be recovered.

10. Fraud, Waste, and Abuse Education

Recipients and Providers are offered fraud, waste and abuse education through a variety of avenues such as Community First website, Member and Provider newsletters, Provider manuals, and the Member Handbook. The information contained in the material includes the definitions and examples of fraud, fraud, waste, and abuse and how to report them.

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

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

XII. ENCOUNTER DATA, BILLING, AND CLAIMS ADMINISTRATION

A. Where to Send Claims/Encounter Data

Submit Paper Claims to:

Community First, Inc.
P.O. Box 240969
Apple Valley, MN 55124

Community First requests that if you are submitting paper claims the following steps should 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).

Submitting Electronic Claims

- **Provider Portal**
  Providers may submit batch claims or individual claims electronically using Community First's secure Provider portal at cfhpprovider.healthtrioconnect.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 at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First's Payor Identification as indicated below:

  - Community First Payor ID: COMMF
  - Community First Receiver Type: F

- **Provider Portal Electronic Billing:**
  - Claim MD
  - Availity

B. Claim Form

Physician and other health care providers must file paper claims on a "CMS-1500 Claim Form" **(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" **(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.

NOTE: Newborn claims should be submitted with all of the required elements above. However, if a Medicaid number for the newborn is unavailable then use the mother's Medicaid ID number with the correct date of birth for the newborn.

C. Monthly Capitation Services

The following is a list of capitated services that Community First is responsible for providing to STAR Members:

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services for children (under age 21)
  - Inpatient and outpatient chemical dependency services.
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)

- Birthing center services if available within the service area
- Chiropractic services
- Dialysis
- Medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services

- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the THSteps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty Physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

For a full listing of benefits and service including exclusions, please see the Texas Provider Procedures Manual at www.tmhp.com.

Providers may call Community First with questions about what services are included in monthly capitation.

D. Emergency Service 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 out-of-network.

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 STAR 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 the Member Services Department at Community First.

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.

E. 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.

F. No Copayments for Medicaid Managed Care Members

In Medicaid Managed Care programs, Members may assume a responsible role in achieving their personal health care by choosing a PCP, actively participating with their PCP to access preventive, primary care services. This collaborative approach to health care delivery does not require or allow the collection of a copayment from the STAR Member.

G. Billing Members

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

H. Time Limit for Submission of Claims

Providers are required to submit claims to Community First 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 Claims Provider Services Unit at **210-358-6200.**

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

I. Claims Submissions

See "Community First Health Plans Provider Billing Guidelines" (Exhibit 26) to review certain aspects and expectations regarding the 837P Professional Health Care Claim transactions.

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 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 Claims Provider Services Unit at **210-358-6200**.

1. Community First will adjudicate all clean claims within 30 days from the date Community First receives the clean claim(s).
2. Community First will notify Providers within 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 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:

- 100% of the current State of Texas Medicaid 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 95% of the current State of Texas Medicaid 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 100% of the current State of Texas Medicaid Fee Schedule, as may be amended from time to time.

Texas Medicaid Fee Schedule is available on www.tmhp.com and or calling **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. § 371.1651-1669.

Supervised Providers. Providers must comply with the requirements of GOV'T § 531.024161, regarding the submission of claims involving supervised Providers.

J. 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:

Community First Health Plans
Attention: Claims Department Secretary
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

K. Special Billing

- The following 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 Medicaid card.
- Make sure the sex of the Member listed on the claim is accurate.
- Value-added services do not require billing.
- Non-Emergency Medical Transportation (NEMT) services do not require billing.

L. Billing and Claims Administration

Coordination of Benefits. A third party may cover some STAR Members (e.g., auto liability, disability, or workers' compensation). In situations where a STAR 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 Payment (EOP) 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 95 days of the third-party insurance EOP. 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 STAR Member's third-party insurance. If a STAR 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 EOP **(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 INS § 843.306 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 INS § 843.306, 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 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 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 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 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 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 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.

M. Claims Questions/Appeals

Providers have the right to appeal the denial of a claim by Community First. The Provider has **120 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 2 years. Providers may submit a "Claim Appeal Submission Form" **(Exhibit 21) or** via mail to:

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

You may also submit the appeal request electronically using Community First's secure Provider portal.

Please direct any claim questions regarding appeals to Community First Health Plan by calling **210-358-6030.**

N. Electronic Funds Transfer and Electronic Remittance Advice

Community First's is partnered with PaySpan for EFT and ERA.

XIII. MEMBER ENROLLMENT AND DISENROLLMENT FROM COMMUNITY FIRST HEALTH PLANS

A. Enrollment

Babies born to Medicaid eligible mothers who are enrolled in Community First will be enrolled into Community First for 90 days following the date of birth. The mother of the newborn may change her newborn to another Plan during the first 90 days but may only do so through the enrollment broker.

B. Automatic Re-enrollment

Community First STAR Members who are dis-enrolled because they are temporarily ineligible for Medicaid will be automatically re-enroll into the same health plan with the same PCP. Temporary loss of eligibility is defined as a period of six (6) months or less. Member has the option to switch plans at this time.

C. Disenrollment

HHSC must approve any request by Community First for such dis-enrollment. The STAR Member may request the right to appeal such decision. The PCP will be responsible for directing the STAR Member's care until the dis-enrollment is made. Request to dis-enroll a Community First STAR Member **is acceptable** under the following circumstances:

- The STAR Member misuses or lends his/her Community First Membership ID Card to another person to obtain services.
- The STAR Member is disruptive, unruly, threatening, or uncooperative to the extent that the STAR Member seriously impairs Community First's or a Provider's ability to service the STAR Member. However, this only occurs if the STAR Member's behavior is not due to a physical or behavioral health condition.
- The STAR 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 PCP or

documentation that indicated sufficiently compelling circumstances that merit disenrollment. HHSC makes the final disenrollment decision.

D. STAR Member PCP Change

If a STAR Member requests a PCP change before the 15th day of the month, the change usually becomes effective on the first day of the following month. Changes received after the 15th day of the month will become effective the first day of the second month following the change request.

XIV. SPECIAL ACCESS REQUIREMENTS

A. Emergency and Non-Emergency Ambulance Transportation

Community First covers ambulance transportation under the following circumstances:

Emergency. When the condition of the STAR Member is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is an emergency service and does not require preauthorization.

Non-Emergency. Any ambulance services ground or air not considered an emergency (see above) must be preauthorized by Community First prior to rendering transportation services.

B. Interpreter/Translation Services

Community First Member services include advocates who can speak to you in English or Spanish, or we can get an interpreter who speaks your language.

Community First has interpretive services available for its STAR 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 STAR 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 STAR Member, please contact Community First's Member Services Department at **210-358-6060**.

C. Community First and Provider Coordination

Community First will make every effort to communicate with and coordinate the delivery of covered services with a STAR 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 Network Management 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 **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 Medicaid, about non-capitated services, and general health plan operations to assist the Provider.

D. Reading/Grade Level Consideration

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

E. Cultural Sensitivity

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

F. Children with Complex and Special Health Care Needs

The PCP for a STAR 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 STAR 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 Tex. Admin. Code § 11.900-11.904.

XV. 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 STAR 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 to **210-358-6040.**

NOTE: These determinations only affect payment for services by Community First. The decision to provide treatment is between the STAR 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 our Member Services Department 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 STAR 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 STAR 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 services listed on the authorization list**.** You can find authorization requirements on our website at CommunityFirstMedicaid.com/prior-authorizations.

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.

XVI. PREVENTIVE HEALTH AND DISEASE MANAGEMENT

STAR 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 STAR Members about the health education services available through Community First. When an education or social need is identified, one can refer a STAR Member to the Preventive Health and Disease Management Department one of several ways:

1. Mail in the "Member Education Request Form" **(Exhibit 11)** to

   Community First Health Plans
   Network Management
   12238 Silicon Drive, Suite 100
   San Antonio, TX 78249

2. Fax the "Member Education Request" form to **210-358-6199.**

3. Contact 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 STAR 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 STAR 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 STAR Members in addressing these concerns to promote wellness. Information gathered from the Member is forwarded to the primary care physician 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 STAR 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 STAR Member satisfaction and retention. Program participation information is routinely mailed to the primary care Physician for review and inclusion in the STAR Member's medical record.

A. Diabetes in Control

Per the CDC's National Diabetes Statistics Report of 2023, (www.cdc.gov/diabetes/php/data) 38.4 million adults ages 18 and older in the United States have diabetes (11.6 percent of the U.S. population). More than 8.7 million of these are undiagnosed (22.8 percent of people with diabetes are undiagnosed). In Bexar County in 2023, more than 16 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, case management, utilization management, health promotion, Member Services, and referrals and information gathered through self-reported Member health assessments. Case Managers screen Members for possible referral to **Diabetes in Control** by reviewing claims histories.

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

behavioral health needs are taken into consideration and incorporated into the plan of care.

B. Asthma Matters

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

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** Members 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 Case 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 primary care physician 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 Primary Care Provider for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data, receive utilization and pharmacy profiles for inclusion in Member's medical record.

C. Healthy Expectations

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** prenatal 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 STAR health plans across the state to expedite the Medicaid eligibility determination and the enrollment of pregnant women into Medicaid managed care. As a result, Medicaid eligibility has been simplified and a process is in place to expedite enrollment within 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 six-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 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 our **Healthy Expectations** have been recognized by the American Association of Health Plans as best practices in case management for prenatal care.

D. 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 a 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.

Members: 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 benefit providers to foster continued improvement.
- Advocating for each member’s needs and goals by understanding and respecting the member’s value system while searching for necessary funding, appropriate treatment and treatment alternatives.
- Integrating medical and behavioral components of treatment to produce long-lasting results.

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

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

E. Lifestyle Management

The **Lifestyle Management** program was developed to address healthy eating, active living, and tobacco avoidance, and aligns with the U.S. Preventive Services Task Force (USPSTF) Recommendations. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Recommendations can be found at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics

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 the **Lifestyle Management** program 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.

F. Hypertension

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

According to the "City of San Antonio's Metropolitan Health District's Mortality in Bexar County, 2017 Report," chronic diseases were responsible for six 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 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 the **Hypertension** program 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.

XVII. 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.

Specialized Service Coordination. The purpose of a Service Coordinator is to maximize a Member's health, well-being, and independence. Service Coordination should consider and address the Member’s situation as a whole, including his or her medical, behavioral, social, and educational needs. All Members have access to a named service coordinator as well as an experienced team supporting them and the Member. In some cases, Member’s require a Specialized Service Coordinator who has special expertise or experience in that Member’s condition. Community First will provide Member’s with these types of service coordinators as appropriate and accordance with that Member’s needs.

2024
STAR PROVIDER MANUAL

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