COMMUNITY FIRST HEALTH PLANS

CHIP | TEXAS Health and Human Services

CHIP PROVIDER MANUAL

COMMUNITY FIRST HEALTH PLANS

PROVIDER SERVICES 210-358-6030

CommunityFirstMedicaid.com

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

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COMMUNITY FIRST
HEALTH PLANS

Community First Health Plans, Inc.

CHIP Provider Manual

Provider Services: 210-358-6030

Covering residents in Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson counties.

CommunityFirstMedicaid.com

QUICK REFERENCE PHONE LIST

CONTACT	PHONE NUMBER
Provider Services	210-358-6030
Network Management/Provider Relations Fax	210-358-6199
Eligibility/Benefits Verification	210-358-6030
Interpreter Services/Sign Language	210-358-6300
Population Health Management Population Health Management Fax	210-358-6050 210-358-6274
Preauthorization Fax	210-358-6040
Behavioral Health Authorization/Care Management	210-358-6403 1-800-434-2347 (Option 4)
Behavioral Health Fax	210-358-6387
TTY (For the Deaf and Hard of Hearing)	711
Network Management	210-358-6030
Claims Inquiries	210-358-6030
Claims Fax	210-358-6014
Electronic Claims	Availity Payor ID: COMMF
Nurse Advice Line (After-hours calls to Community First are forwarded to the Nurse Advice line.)	1-800-434-2347
Preventive Health and Disease Management Preventive Health and Disease Management Fax	210-356-6105 210-358-6099
Pharmacy-Navitus Health Solutions	1-877-908-6023
Vision Inquiries Envolve Benefit Options	 1-800-334-3937
Dental Inquiries DentaQuest MCNA Dental United Healthcare Dental	 1-800-516-0165 1-800-494-6262 1-877-901-7321

TABLE OF CONTENTS

I. CHIP AND CHIP PERINATE NEWBORN PROGRAMS

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

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

A. INTRODUCTION

1. BACKGROUND AND OBJECTIVES

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

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

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

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

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

We will review this Manual annually or sooner if indicated. We will notify our network of changes. Community First publishes and distributes email and print newsletters to all Network Physicians and Providers. These communications include information such as CHIP/CHIP Perinate Newborn services, policies and procedures, statutes, regulations, and claims processing information. Community First also uses fax alerts, banner messages, special mailings, our website, and secure Provider Portal as additional means to communicate changes/updates to you and your staff.

Following the initial orientation session for Community First CHIP/CHIP Perinate Newborn Network Physicians and Providers, Community First hosts ongoing training sessions that include topics and information as requested by Providers or deemed necessary by Community First or the Texas Health and Human Services Commission (HHSC). This includes changes to covered services, authorization requirements, and claims submission procedures and appeal timeframes.

2. ROLE OF THE CHIP/CHIP PERINATE NEWBORN PRIMARY CARE PROVIDER (PCP)

Primary Care Providers (PCPs) play an integral role in helping meet the objectives of the CHIP program. The program places its main focus on the total well-being of the Member, while providing a "Medical Home" where the Member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. The "medical home" concept should assist in establishing a Member and Provider relationship and, ultimately, better health outcomes. Members are encouraged to become more involved in their own health care and maintain their own wellness. In addition, the PCP is responsible for referring and obtaining authorization for Members needing specialty services to Network Providers.

Who can serve as a Primary Care Provider (PCP)?
Credentialed Providers in the following specialties can serve as a PCP:

- Advanced Family Practice Nurse
- Family Practitioner
- General Practitioner
- Internal Medicine Practitioner
- OB/GYN
- Geriatrician
- Certified Nurse Midwife
- Physician Assistant
- Specialist (when appropriate)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

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

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

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

- Supervision, coordination, and provision of care to each assigned Member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned Member.
- Maintaining the Member's medical record, including documentation for all services provided to the Member by the PCP, as well as any specialists, behavioral health, or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiating a behavioral health referral.

Please review American Academy of Pediatrics Recommendations for Preventive Pediatric Health and CDC Recommended Child and Adolescent Immunization Schedule.

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

The PCP will provide or arrange for the provision of covered services, telephone consultations, or both 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, Health Care Providers, and specialists and for managing, monitoring, and documenting the services of other Providers.

It is important to educate CHIP Members to seek services from their designated PCP before accessing other specialty health care services, with the following exceptions:

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

3. ROLE OF THE CHIP/CHIP PERINATE NEWBORN SPECIALTY CARE PROVIDER

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

4. NETWORK LIMITATIONS

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

5. ROLE OF PHARMACY

Community First makes payment for prescriptions of covered outpatient drugs only to Pharmacy Providers contracted with Navitus. CHIP/CHIP Perinate Newborn Members may receive medically necessary prescriptions from the network pharmacy of their choice.

Pharmacies must verify the eligibility of the Member prior to rendering services and adhere to the Formulary and Preferred Drug List. The only drugs eligible for Navitus reimbursement are listed in the current Texas Listing of National Drug Codes. When HHSC-approved drugs are furnished by prescription, payment is made to pharmacies contracted with Navitus.

Community First is responsible for assisting Members with medication management through their Primary Care Provider and/or specialists.

6. ROLE OF MAIN DENTAL HOME

Members may choose their main dental homes. Dental plans will assign each Member to a main dental home if they do not choose one in a timely manner. Whether chosen or assigned, each Member who is six months or older must have a designated 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 can serve as a main dental home.

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

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

7. ACCESS TO TELEMEDICINE, TELEMONITORING, AND TELEHEALTH

CHIP Members have access to Providers who offer telemedicine, telemonitoring, and telehealth services. To be eligible for reimbursement, distant site Physicians providing treatment must meet the service requirements outlined in Texas Government Code - GOV'T § 531.0217.

As a second option to face-to-face visits, any Provider in the Community First network can offer telehealth services to Community First Members.

Telehealth services are virtual health care visits with a Provider through a mobile app, online video, or other electronic method. These may include, but are not be limited to telemedicine, telemonitoring, and telehealth services.

Community First treats telehealth services with In-Network Providers in the same way as face-to-face visits with In-Network Providers. A telehealth visit with an in-network Community First Provider does not require prior authorization. A telehealth visit with an in-network Community First Provider is subject to the same co-payments, co-insurance, and deductible amounts as an in-person visit with an In-Network Provider. Providers may be reimbursed for a patient site facility fee when services are performed by a:

- County Indigent Health Care Program
- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Outpatient Hospital

NOTE: A facility fee is not available if the patient site is the patient's home. Providers delivering telemedicine, telemonitoring, and telehealth services to eligible Community First Members should reference the Texas Medicaid Provider Procedures Manual, for billing guidance and applicable modifiers.

B. CHIP AND CHIP PERINATE NEWBORN COVERED SERVICES

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

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

There is no lifetime maximum on benefits; however, lifetime limitations do apply to certain services, as specified in the following chart. There is no spell of illness limitation.

1. CHIP SCHEDULE OF BENEFITS

CHIP COVERED SERVICE	LIMITATIONS
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as approved by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free of-charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, Physician, and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate Provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples.	**Requires authorization** for non-emergency care and care following stabilization of an emergency condition. **Requires authorization** for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

CHIP COVERED SERVICE	LIMITATIONS
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	
Skilled Nursing Facilities (including Rehabilitation Hospitals) Services include but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	**Requires authorization** and Physician prescription. 60 days per 12-month period limit.

CHIP COVERED SERVICE	LIMITATIONS
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center), and Ambulatory Health Care Center Services include but are not limited to, the following services provided in a hospital clinic or emergency department, a clinic or health center, a hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia associated with dental care when provided in a licensed ambulatory surgical facility • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate Provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical implants	**May require authorization** and Physician prescription.

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

CHIP COVERED SERVICE	LIMITATIONS
Physician/Physician Extender Professional Services Services include but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient, and outpatient services • Laboratory, X-rays, imaging, and pathology services, including technical component and professional interpretation • Medications, biologicals, and materials administered in a Physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ◦ Administration of anesthesia by a Physician (other than surgeon) or CRNA ◦ Second surgical opinions ◦ Same-day surgery performed in a hospital without an overnight stay ◦ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and Out-of-Network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate Provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples.	**May require authorization** for specialty services.

CHIP COVERED SERVICE	LIMITATIONS
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and tumor growth or its treatment.	
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery).
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including, but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids, including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	**May require prior authorization** and Physician prescription. $20,000, 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).

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

CHIP COVERED SERVICE	LIMITATIONS
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but are not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.	**May require prior authorization.** Does not require PCP referral. When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be Providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or Physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of, i.e. day treatment and in-home services), patient and family education, and crisis services.
Inpatient Substance Misuse Treatment Services Inpatient substance misuse treatment services include but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	**Requires prior authorization** for non-emergency services. Does not require PCP referral.

CHIP COVERED SERVICE	LIMITATIONS
Outpatient Substance Misuse Treatment Services Outpatient substance misuse treatment services include but are not limited to the following: • Prevention and intervention services that are provided by Physician and Non-Physician Providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services ◦ Intensive outpatient services is defined as an organized, non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ◦ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. • Partial hospitalization	**May require prior authorization.** Does not require PCP referral.
Rehabilitation Services • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include but are not limited to, the following: ◦ Physical, occupational, and speech therapy ◦ Developmental assessment	**Requires prior authorization** and Physician prescription.
Hospice Care Services Services include but are not limited to, the following: • Palliative care, including medical and support services, for those children who have six months or less to live to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services	**Requires authorization** and Physician prescription. Services apply to the hospice diagnosis. Up to a maximum of 120 days with a six-month life expectancy. Patients electing hospice services may cancel this election at any time.

CHIP COVERED SERVICE	LIMITATIONS
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Covered services include but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department and ancillary services and Physician services 24 hours a day, 7 days a week, both by in-network and Out-of-Network Providers • Medical screening examination • Stabilization services • Access to DSHS-designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	**Requires authorization** for post-stabilization services. The health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.
Transplants Services include but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses	**Requires authorization.**
Vision Benefit Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	**Does not require authorization** for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. The health plan may reasonably limit the cost of the frames/lenses.
Chiropractic Services Covered services do not require Physician prescription and are limited to spinal subluxation.	**Does not require authorization** for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). **Requires authorization** for additional visits.

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

Breast Pump Coverage in Medicaid and CHIP

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

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

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is approved for 12 months of Medicaid coverage, beginning on the date of birth.

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

Emergency Dental Services

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

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

Non-Emergency Dental Services

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

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

2. CHIP PERINATE NEWBORN SCHEDULE OF BENEFITS

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as approved by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free of-charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, Physician, and related medical services, such as anesthesia, associated with dental care • Surgical implants • Other artificial aids, including surgical implants • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and tumor growth or its treatment.	**Requires authorization** for non-emergency care and care following stabilization of an emergency condition. **Requires authorization** for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
• Inpatient services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	
Skilled Nursing Facilities (including Rehabilitation Hospitals) Services include but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	**Requires authorization** and Physician prescription. 60 days per 12-month period limit.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center), and Ambulatory Health Care Center Services include but are not limited to the following services provided in a hospital clinic or emergency department, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit	**May require authorization** and Physician prescription.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Physician/Physician Extender Professional Services Services include but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient, and outpatient services • Laboratory, X-rays, imaging, and pathology services, including technical component and professional interpretation • Medications, biologicals, and materials administered in Physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ◦ Administration of anesthesia by Physician (other than surgeon) or CRNA ◦ Second surgical opinions ◦ Same-day surgery performed in a hospital without an overnight stay ◦ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and Out-of-Network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and palate; or ◦ severe traumatic, skeletal, and congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and tumor growth or its treatment.	**May require authorization** for specialty services.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers services rendered to a newborn immediately following delivery.
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but are not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids, including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	**May require prior authorization** and Physician prescription. $20,000, 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).
Home and Community Health Services Services that are provided in the home and community, including, but are not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN, LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical, and occupational therapies	**Requires prior authorization** and Physician prescription. Services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are provided on an intermittent level and are not intended to provide 24-hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities, including, but are not limited to: • Neuropsychological and psychological testing	**Requires prior authorization** for non-emergency services. Does not require PCP referral. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but are not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute, outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.	**May require prior authorization.** Does not require PCP referral. When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Qualified Mental Health Provider Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be Providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or Physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of, i.e. day treatment and in-home services), patient and family education, and crisis services.
Inpatient Substance Misuse Treatment Services Inpatient substance misuse treatment services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	**Requires prior authorizatio**n for non-emergency services. Does not require PCP referral.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Outpatient Substance Misuse Treatment Services Outpatient substance misuse treatment services include, but are not limited to the following: • Prevention and intervention services that are provided by Physician and Non-Physician Providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services ◦ Intensive outpatient services is defined as an organized, non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ◦ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. • Partial hospitalization	**May require prior authorization.** Does not require PCP referral.
Rehabilitation Services • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: ◦ Physical, occupational, and speech therapy ◦ Developmental assessment	**Requires prior authorizatio**n and Physician prescription.
Hospice Care Services Services include, but are not limited to, the following: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services	**Requires authorizatio**n and Physician prescription. Services apply to the hospice diagnosis. Up to a maximum of 120 days with a six-month life expectancy. Patients electing hospice services may cancel this election at any time.

CHIP PERINATE NEWBORN COVERED SERVICE	LIMITATIONS
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Covered services include, but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department and ancillary services and Physician services 24 hours a day, 7 days a week, both by in-network and Out-of-Network Providers • Medical screening examination • Stabilization services • Access to DSHS-designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	**Requires authorization** for post-stabilization services. Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.
Transplants Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses	**Requires authorization.**
Vision Benefit Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	**Does not require authorization** for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. The health plan may reasonably limit the cost of the frames/lenses.
Chiropractic Services Covered services do not require Physician prescription and are limited to spinal subluxation	**Does not require authorization** for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). **Requires authorization** for additional visits.

3. CHIP/CHIP PERINATE NEWBORN EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (e.g., cannot be prescribed for family planning).

- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and investigational medical, surgical, or other health care procedures or services which are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to, artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by Community First.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by Community First except for emergency care and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by Community First.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy, and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care. (Routine foot care does not include treatment of an injury or complications of diabetes.)
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails. (This does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails.)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purpose.
- Custodial care. (Care that assists a **child** with activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This exclusion does not apply to hospice services.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.

- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses for transplants.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

NOTE: The exclusions for CHIP Perinate Newborns match those listed above with the exception of the following:

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

4. DURABLE MEDICAL EQUIPMENT (DME) AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY

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

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

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See "Ostomy Supplies."
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold	X		
Dental Devices	X		
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/ Chux	X		Coverage limited to children aged 4 or over only when prescribed by a Physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/ Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times, these items are dispensed in a kit which includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner- or middle-ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function, or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders, a non-function, or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the Physician and authorized by plan). Physician documentation to justify prescription of formula must include: • identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product. Does not include formula: • For Members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding. • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product). • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth, or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blended and used with an enteral system that are not medically necessary are **not** covered, regardless of whether these regular food products are taken orally or parentally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children aged 4 or over only when prescribed by a Physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir, and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individuals with an indwelling urinary catheter.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes, and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/ Diabetic			See "Diabetic Supplies."
Needles and Syringes/IV and Central Line			See "IV Therapy and Dressing Supplies/Central Line."
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See "Saline, Normal."
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/ sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when Community First has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; or c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See "Needles/Syringes."
Tape			See "Dressing Supplies," "Ostomy Supplies," "IV Therapy Supplies."
Tracheostomy Supplies	X		Cannulas, tubes, ties, holders, cleaning kits, etc., are eligible for coverage.
Under Pads			See "Diapers/Incontinent Briefs/Chux."
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Urinary, External Catheter, and Supplies		X	Exception: Covered when used by incontinent males where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan.
Urinary, Indwelling Catheter, and Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set, and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See "Ostomy Supplies."

5. PHARMACY PROGRAM

Member Prescriptions

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

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

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

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

It is important that Providers know about other prescriptions and over-the-counter medications, vitamins, or herbal supplements the Member is taking.

Preferred Drug List

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

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

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

Formulary Drug List

The Texas Drug Code Formulary covers more than 32,000-line items of drugs including single source and multi-source (generic) products. You can check to see if a medication

is on the state's formulary list. Remember, before prescribing these medications to your patient(s), the medication may first require PA.

If you would like to request a drug to be added to the formulary, please contact HHSC at TXVendorDrug.com/About/Contact-Us.

Over-the-Counter Drugs

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

Network Pharmacy

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

Mail Order Forms for Members

You can assist a Member in completing a mail order form if you are prescribing a maintenance medication. Instructions and helpful links for the mail order process can be found online in Community First Member Resources at Medicaid.CommunityFirstHealthPlans.com/Resources/Pharmacy.

Brand-Name Medications

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

Pharmacy Prior Authorization (PA)

Pharmacy prior authorization may be required if:

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

Procedure for Obtaining Pharmacy Prior Authorization

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

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

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

Completed PA forms can be faxed 24/7 to Navitus at **1-855-668-8553**. Prescribers can also call Navitus Customer Care at **1-877-908-6023** to speak with the Prior

Authorization Department from 8:00 a.m. to 5:00 p.m., Monday through Friday (CST) to submit a PA request over the phone. After hours, Providers will have the option to leave 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 dispensing 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.

Emergency Refills

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. They can also be reported to Navitus' Network Department by calling **1-877-908-6023**. Providers may initiate prior authorization through the secure online Community First Provider Portal or via fax at **210-358-6274**.

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 Community First Provider Services at **210-358-6030** should you have questions regarding covered services.

6. CHIP AND CHIP PERINATE NEWBORN EXTRA BENEFITS (VALUE-ADDED SERVICES)

CHIP and CHIP Perinate Newborn Members receive the following extra benefits or Value-Added Services through Community First. If you have any questions about Value-Added Services, please call **210-358-6055**.

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATION**
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or hard of hearing can call 711.	

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATION**
Extra Help Getting a Ride (bus passes) for Members, their siblings, and their parents or legal guardians to places, such as: • The grocery store • Community-based services • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices to submit applications for employment and housing • Social Security Administration-approved Physician for appointments requested for disability determination and services	Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. For non-medical related use only. This service is available only for bus service routes within San Antonio and routes are offered by VIA Metropolitan Transit.
Extra Dental Services, including: • Up to 50% off dental & orthodontic services • Free exams and x-rays every 6 months	For Members ages 21 and older and their family members who do not have Medicaid or CHIP dental coverage.
Extra Vision Services, including up to $125 for frames or $75 for contact lenses	Applies to either frames or contact lenses and must be medically necessary. Available every year for Members through age 18. Glasses or contacts can only be replaced when there is a change in vision. Lost or broken glasses or contacts may be replaced as allowed by the Benefit Program.
Disease Management, including: • Y Weight Loss Program - 16 Weeks to Wellness: a no-cost program for individuals interested in implementing and maintaining a healthy lifestyle. Program includes a free 4-month YMCA membership for two adults and up to 4 children. • YMCA Diabetes Prevention Program: a no-cost, year-long, evidence-based program to help individuals age 18 and older at risk of developing Type 2 Diabetes. Program includes a free 4-month YMCA membership for two adults and up to 4 children.	Must attend education sessions 1-4 to receive YMCA membership. Members must be 18 or older to participate in the YMCA Diabetes Prevention Program and 13 or older to participate in the Y Weight Loss Program.
Drug Store Services/Over-the-Counter Benefits • Up to 80% discount on prescription medicines for Member's family members who do not have Medicaid or CHIP coverage • One-time $50 allowance for over-the-counter items, including household, personal care, oral care and children's items, for Members actively participating in Complex Case Management for more than 60 days	Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATION**
Sports and School Physicals One free physical per calendar year to be used for sports, school, or other physical activities	For Members through age 18. Provider may perform the physical in conjunction with a CHIP well-child checkup or an acute care visit.
Help for Members with Asthma who participate in Asthma Matters: Asthma Management Program, including: • 1 adult or child size mask with aerosol chamber each year • 1 allergy-free protector pillowcase each year • $10 gift card for completing asthma education • $10 gift card for receiving a flu shot • Up to $80 in gift cards for completing home visits with San Antonio Kids BREATHE ($35 for first visit, $10 for second visit, $35 for third visit)	Gift cards must not be used to purchase beer, wine, alcohol, cigarettes, or over-the-counter drugs.
Home visits for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations	
Healthy Play and Exercise Programs, including: • Free Zumba classes for Members and their families with a free fitness giveaway, including the choice of a frisbee, water bottle, or exercise bands • Free Bike Safety and Repair Program with free giveaway	
Health and Wellness Services, including: • Free toddler booster seat for children age 4 through 10 who are current with their CHIP well-child checkups • Free, personalized support and the tools and strategies to keep you motivated and help you become tobacco-free by phone or online. Includes coaching, education, activities and more • Free notary services for documents such as medical power of attorney, health agent of record, and living wills • Opportunity to attend in-person and virtual seasonal and community Health Education Special Events at no-cost where Members may receive health education on topics such as telehealth, healthy habits, new benefits, and more	Toddler booster seat to be used according to safety guidelines. To receive notary services, Members must have a valid, state-issued identification card or driver's license.
Inpatient Follow-up Incentive Program, for Members who participate in Healthy Mind: Behavioral Health Program • $25 gift card for completing a follow-up visit with a Behavioral Health Provider within 7 days of discharge from a mental health hospital or facility upon request	Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATION**
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	
Phone Assistance for CHIP Members who qualify for the Federal Lifeline Program. Members can get a free smart phone with minutes, text, storage, and international calling as determined by the vendor. Unlimited calls to Member Services, through our toll-free line and free health education text messages.	Limited to one per household. Member may get a free cell phone or use their own. Service provided by the following plan options depending on coverage area: SafeLink Wireless and Life Wireless.
Gift Programs, including: • Up to $25 in gift cards for completing the Community First Health Assessment and receiving Meningococcal, Tdap, and HPV adolescent immunization series (for children ages 9-13) • $25 gift card for Members ages 6-24 months who get the full series of the flu vaccine and complete the Community First Health Assessment • $10 gift card for new Community First CHIP Members who complete the Community First Health Assessment and provide an email address • Up to $20 in gift cards for completion of the Rotavirus immunization series for Members ages 42 days through 8-months-old • Up to $90 in gift cards, per child, for completion of a preventive health assessment and CHIP well-child checkups ages 2 months through 30 months ($10 gift card each, for completing the 2, 4, 6, 9, 12, 15, 18, 24, and 30-month checkups) • Up to $180 in gift cards for completing a preventive health assessment and CHIP well-child checkups ages 3 through 18 years • Up to $60 in gift cards for Members with diabetes participating in Diabetes in Control: Diabetes Management Program: • $20 gift card for completing the Community First diabetes assessment • $10 gift card for completing diabetes education • $10 gift card for receiving a dilated eye exam • $10 gift card once every six months for submitting A1C results	Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.

C. COORDINATION WITH OTHER STATE PROGRAM SERVICES (NON-CAPITATED SERVICES)

1. TEXAS AGENCY-ADMINISTERED PROGRAMS AND CASE MANAGEMENT SERVICES

Community First is required through its contractual relationship with HHSC, to coordinate with public health entities regarding the provision of services for essential public health services. Providers must assist Community First in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving Members.
- Reporting to the local public health entity for Tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact within (1) one business day of identification:
  - Ensuring all Members who have TB or are at-risk are screened for TB.
  - Accessing procedures for reporting TB and appropriate DSHS forms from DSHS.State.TX.US/IDCU/Disease/TB/Forms.
    12238 Silicon Drive, Ste. 100, San Antonio, Texas 78249
- Reporting all confirmed cases of STD/HIV to the local public health entity for STD/HIV contact investigation, and evaluation and preventive treatment of persons whom the Member has come into contact:
  - Accessing required forms for reporting from DSHS.Texas.gov/HIVSTD/Reporting/ or by calling Community First Member Services Department.
  - Keeping information confidential about Members who have received STD/HIV services.
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment.
- Using material from HHSC available at HHS.Texas.gov/Services/Disability.
- Complying with the release of records within 45 days so that screening may be completed.

2. ESSENTIAL PUBLIC HEALTH SERVICES

Community First works with the Health and Human Services Commission (HHSC) through a Memorandum of Understanding (MOU) to provide essential public health services. Community First makes a good faith effort to enter into a subcontract for covered services with Essential Public Health Entities in support of its mission to diagnose and investigate diseases, health problems, and threats to the public's health. Covered services that could be provided by Public Health Entities include, but are not limited to, the following services:

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

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

Dental Services

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

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

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

Mental Health Targeted Case Management

Community First, working with the Member's PCP through the Local Mental Health 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 with mental retardation or related condition.
- Case Management for people with serious emotional disturbance (children ages 3 through 17).
- Individual community support services Service Coordination for people with mental retardation or related condition (adult or child).

An 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.

An 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

Service	Proc Code	Modifier	Limitation
Routine Case Management (Child and Adolescent)	T1017	TF and HA	32 units (8 hours) per calendar day for people less than 18 years of age
Intensive Case Management (Child and Adolescent)	T1017	TG and HA	32 units (8 hours) per calendar day for people less than 18 years of age.

Mental Health Rehabilitation

Service	Proc Code	Modifier	Limitations
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 and Adolescent, Individual	H0034	HA	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Medication Training and Support, Child and Adolescent, with Other, Individual	H0034	HA and HQ	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Medication Training and Support, Child and 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

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

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

Texas Commission for the Blind Case Management

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:

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

Members can apply for services and get more information on any Division for Blind Services program and Providers can help Members apply for services at HHS.Texas.gov/Services/Disability/Blind-Visually-Impaired or call **1-877-787-8999**.

Tuberculosis (TB) Services Provided by DSHS-Approved Providers

Community First Providers must report all confirmed or suspected cases of TB for a contact investigation and directly observed therapy (DOT) to Local Tuberculosis Control Health Authority (LTCHA) within one (1) working day of identification, using the procedures and forms for reporting TB adopted by DSHS located online at DSHS.Texas.gov/Tuberculosis-TB/Texas-DSHS-TB-Program-TB-Forms-Resources.

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

Communicable/Infectious Diseases

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

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

Lead Screening Program

Community First Providers must follow the **Blood Lead Screening and Testing Guidelines for Texas Children** located online at DSHS.Texas.gov/Blood-Lead-Surveillance-Group/Educational-Materials/Texas-Childhood-Lead Poisoning/Screening. 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 and Disease Surveillance Unit
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Phone: **1-800-588-1248**
Website: DSHS.State.TX.US/Lead

Women, Infants, and Children Program (WIC)

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

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

WIC Eligibility Requirements

- **Meet the income guidelines.** Households with incomes at or below the Medicaid Eligibility Threshold of the Federal Poverty Level are eligible according to the Texas WIC Income Guidelines. WIC determines income based on gross income. WIC counts all Members of a household, related or unrelated. WIC counts an unborn baby as a household member.
- **Be at nutritional risk.** WIC clients receive an initial health and diet screening at a WIC clinic to determine nutritional risk. WIC uses two main categories of nutritional risk: (1) medically based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and (2) diet-based risks such as poor eating habits that can lead to poor nutritional and health status.

Clients will be counseled at WIC about these risks and the outcome influenced by nutrition education and nutritious foods provided by WIC.
- **Live in Texas.** WIC clients usually receive services in the county where they live. U.S. citizenship is not a requirement for eligibility.
- Clients must apply **in person** except in certain limited cases.

All WIC services are free to those who are eligible.

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

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

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

Hospice Services

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

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

When clients elect hospice services, they waive their rights to all other CHIP services related to their terminal illness. They do not waive their rights to CHIP services unrelated to their terminal illness. Medicare and CHIP Members must elect both the Medicare and CHIP Hospice programs. Individuals who elect hospice care are issued a Texas Benefits Medicaid Card with "HOSPICE" printed on it. Members may cancel their election at any time.

HHSC pays the Provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:
- Routine home care
- Continuous home care
- Respite care
- Inpatient care

For HHSC hospice billing questions, visit HHS.Texas.gov/Services/Health/Palliative-Care/Hospice-Care.

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

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

Mail paper claims to the following address:

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

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

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

The request for the hearing may be in the form of a petition or letter. It must state the reason for appeal. You must be notified in writing at least 20 days before the date of the formal appeal hearing, or, if the hearing is expedited, 10 days before the formal appeal hearing. You may submit written notification to HHSC of withdrawal of the hearing request any time before conclusion of the formal appeal hearing.

Texas Vaccines for Children Program

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

Qualified CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application Form located on the DSHS TVFC website at DSHS.State.TX.US/Immunize/TVFC/Default.shtm.

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

D. BEHAVIORAL HEALTH

1. BEHAVIORAL HEALTH DEFINITIONS

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

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

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

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

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder; or
- Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

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

2. BEHAVIORAL HEALTH COVERED SERVICES

- 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
- Attention Deficit Hyperactivity Disorder (ADHD)
- Health Home
- Self-referral (any network Behavioral Health Provider)
- PCP referral
- Target Case Management and Rehabilitative Services
- Substance use disorder services

3. PRIMARY CARE PROVIDER ROLE IN BEHAVIORAL HEALTH

Primary Care Providers (PCPs) are responsible for coordinating the Member's physical and behavioral health care including making referrals to behavioral health practitioners when necessary. However, the Member does not need a referral to access mental health

or substance use disorder treatment with a participating Community First Provider. The PCP serves as the "medical home" for the patient.

In addition, PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies such as the National Institute of Health. PCPs can also reference Community First's website, CommunityFirstMedicaid.com for more information. PCPs may provide behavioral health-related services within the scope of their practice.

4. PRIMARY CARE PROVIDER REQUIREMENTS FOR BEHAVIORAL HEALTH

PCP may, in the course of treatment, refer a patient to a Behavioral Health Provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of their 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.

Primary Care Providers are required to:

- Send the Behavioral Health Provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the Member's physical and behavioral health status. The report must include, at a minimum:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify Members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the Behavioral Health Provider who referred the Member.

5. BEHAVIORAL HEALTH PROVIDER REQUIREMENTS

Behavioral Health Providers agree to:

- Refer Members with known or suspected physical health problems or disorders to the PCP for examination and treatment, with the consent of the Member or the Member's legal guardian.
- Only provide physical health services if such services are within the scope of the network practitioner's clinical licensure.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the consent of the Member or the Member's legal guardian. Contact Members who have missed appointments within 24 hours to reschedule appointments.
- Network Facilities and Community Mental Health Centers must ensure Members who are discharging from inpatient care are scheduled for outpatient follow-up and/

or continuing treatment prior to the Member's discharge. The outpatient treatment must occur within seven days from the date of discharge.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities.
- Provide an attestation to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of Mental Health Rehabilitative (MHR) and Targeted Case Management (TCM) services as outlined in the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Uniform Managed Care Manual, Chapter 15 (as part of Credentialing process).
- Annually complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA) assessment tools if providing MHR and TCM.
- Use RRUMG as the medical necessity criteria for MHR and TCM services.
- Qualified Mental Health Professionals for Community Services (QMHP-CS) requirement minimums are as follows:
  - Demonstrated competency in the work to be performed;
  - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, Physician Assistant, gerontology, special education, educational psychology, or be a Registered Nurse (RN);
  - An LPHA is automatically certified as a QMHP-CS. A Community Services Specialist (CSSP), a Peer Provider, and a Family Partner can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. A Peer Provider must be a certified peer specialist, and a Family Partner must be a certified Family Partner.
  - The name of a performing Provider is not required on claims submitted to Community First if that Provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs, and Targeted Case Managers).
- A qualified Provider of Mental Health Rehabilitative and Targeted Case Management services must:
  - Demonstrate competency in the work performed.
  - Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, Physician Assistant, gerontology, special education, educational psychology.
  - Be a Registered Nurse (RN).
  - Follow HHSC established qualification and supervisory protocols.
- Community First is prohibited from establishing additional supervisory protocols with respect to the Providers of TCM or MHR.
- Training and certification to administer the Adult Needs and Strength Assessment (ANSA) for Members.
- 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.

Reimbursement
Claims billed by a Physical Health Provider will be considered for reimbursement when billed with an ADHD diagnosis code. Reimbursement will be based on the prevailing Texas Medicaid fee schedule and the contracted reimbursement agreement with Community First.

ICD-10 Diagnostic Codes for Behavioral Health Claims
Medical record documentation and referral information must be documented using the ICD-10 classifications, as well as the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Laboratory Services
Behavioral Health Providers should facilitate the provision of in-office laboratory services for behavioral health Members whenever possible or at a location that is within close proximity to the Behavioral Health Provider's office.

Assessment Instruments for Behavioral Health Available for PCP Use

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

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

6. BEHAVIORAL HEALTH SERVICES

Member Access to Behavioral Health Services

A CHIP Member can use behavioral health services through:

- Self-referral to any Network Behavioral Health Provider
- Contacting Community First at **210-358-6100** or **1-800-434-2347** to obtain a list of Network Behavioral Health Providers

Community First does not require a PCP referral for CHIP Members to schedule an initial consultation with a Network Behavioral Health Provider. Outpatient behavioral health services **beyond** the first 20 visits must be preauthorized by sending a Behavioral Health Request for Authorized Services and Treatment Plan to Community First's Population Health Management Department via fax to **210-358-6387**. Medical necessity documentation must be submitted prior to the 20th visit.

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

- An initial/concurrent review of Members admitted to the hospital or receiving services to determine coverage
- Assistance with obtaining information and checking eligibility; and
- 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. Providers must fax a completed Psychological Testing Request Form to **210-358-6387**.

Attention Deficit Hyperactivity Disorder

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

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

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

Substance Use Disorder (SUD)

The "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)," no longer uses the terms substance abuse and substance dependence, rather it refers to Substance Use Disorders (SUD), 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.

SUD Telemedicine and Telehealth Services

Providers of SUD services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not Provider convenience.

Providers must provide SUD services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659.

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRD) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT services can be provided

by Physicians, registered nurses, advanced practice nurses, Physician Assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-Licensed Providers may deliver SBIRT under the supervision of a Licensed Provider if such supervision is within the scope of practice for that Licensed Provider. The same SBIRT training requirements apply to Non-Licensed Providers.

A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

Screening

Screening persons for problems related to alcohol or substance use identifies the person's level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another Provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, annoyed, guilty, eye-opener (CAGE) questionnaire
- Car, relax, alone, forget, family or friends, trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk.

Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivational interviewing techniques that are focused on raising the person's awareness of their alcohol or substance use and its consequences. Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

Referral to Treatment

If the Provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment Provider. Referral is an essential component of the SBIRT intervention because it ensures that all persons who are screened have access to the appropriate level of care.

Coordination Between Behavioral Health and Physical Health Services

Community First recognizes that communication is the link that unites all the service components and is a key element in any program's success. To advance this objective, Providers are required to obtain a consent for disclosure of information from the Member, permitting exchange of clinical information between the Behavioral Health Provider and the Member's Physical Health Provider.

If the Member refuses to release the information, they should indicate their refusal on the release form. In addition, the Provider will document the reasons for declination in the medical record. Community First monitors compliance of the Behavioral Health Providers to ensure a consent and an Authorization To Disclose Information Form has ILOS been signed by the Member. Community First also ensures that regular reports are sent to the PCP for Members agreeing to the disclosure.

Community First promotes the development of Integrated Primary Care (IPC) at the Member's Medical Home (Primary Care) and involves the integration of behavioral health services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same Provider ideally, or by the Behavioral Health Provider seeing the Member in tandem with the PCP. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes behavioral health care that occurs either before or after the primary care and at the same or different location.

Medical Records Documentation and Referral Information

When assessing a CHIP Member for behavioral health services, Providers must use the DSM-IV multi-axial classification and report axes I, II, II, IV, and V. Community First may require use of other assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and the assessment/outcome information in the CHIP Member's medical record.

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

Consent for Disclosure of Information

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

Court-Ordered Commitments

Community First will provide covered Medicaid inpatient services to Members, birth through 20 years of age and 65 years of age and older, who have been ordered to receive inpatient psychiatric services under court of competent jurisdiction, including services ordered pursuant to the Texas Health and Safety Code Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Community First cannot deny, reduce, or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for Members, birth through 20 years of age and 65 years of age and older. Community First will not deny, reduce, or controvert the court orders for Medicaid inpatient mental health covered services for Members of any age if the court ordered services are delivered in an acute care hospital. Community First may not limit substance use disorder treatment or outpatient mental health services for Members of any age provided pursuant to a court order or a condition of probation. The Member can only appeal the commitment through the court system. These requirements are not applicable when the Member is considered incarcerated, as defined by Uniform Managed Care Manual (UMCM) Chapter 16.

To ensure services are not inadvertently denied, Providers must contact Community First and provide telephonic or written clinical information as well as a copy of the court order.

Any professional services provided that are part of a court order must be billed with an H9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court-ordered services that require authorization or notification per Community First's prior authorization list must also have an authorization.

Coordination with the Local Mental Health Authority

Providers rendering behavioral health services who believe CHIP Members qualify for targeted case management or rehabilitation services through the Local Mental Health Authority (LMHA) may refer the Member to the LMHA office nearest to the CHIP Member. The LMHA will assess the CHIP Member to determine if they meet criteria for Severe and Persistent Emotional Disturbance (SPMI) or Severe Emotional Disturbance (SED). For LMHA information, call the Center for Healthcare Services **210-261-2427**.

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

Behavioral Health Assessment Instruments Available for PCP Use

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

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

Focus Studies and Utilization Management Reporting Requirements

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

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

Procedure to Follow Up on Missed Appointments

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

Discharge Planning and Aftercare

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

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

Summary Reports to Primary Care Providers

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

Inpatient Authorization

Community First is responsible for authorized inpatient hospital services including services provided in freestanding psychiatric facilities.

7. EMERGENCY BEHAVIORAL HEALTH SERVICES

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

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 department or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the Member is a danger to self or others and is unable to go to an emergency care facility.

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

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

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

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 themselves or others and is able to cooperate with treatment.

8. BEHAVIORAL HEALTH VALUE-ADDED SERVICES

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

E. EMERGENCY, URGENT, AND ROUTINE CARE SERVICES

1. DEFINITIONS OF EMERGENCY, URGENT, AND ROUTINE CARE

Medically necessary health services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided. Medically necessary health services must also be provided at the most appropriate level or supply of service which can safely be provided and could not be omitted without adversely affecting the Member's physical health or the quality of life.

Except for emergency care in a true emergency, Members are encouraged to contact the PCP prior to seeking care. In the case of a true emergency, Members are encouraged to visit their nearest emergency department.

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

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

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

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

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

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

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

Urgent Admission Notification Process

- Unplanned Admissions Requirements: Community First requires urgent admission notification within 24 hours of admission. Facilities are to submit supporting clinical information within 48 hours of the admission. Observation stays do not require authorization.
- Documentation Requirements: Supporting documentation includes but is not limited to the Physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required.

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

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

Services provided at the Urgent Care Clinics are limited to:

- **After-hours Urgent Care**

Weekdays/Weekends and Holidays	5:30 p.m. to 8:30 a.m.
Day Preceding a Holiday	After 5:00 p.m.
Day Following a Holiday	Before 8:30 a.m.

Urgent Care Referral During Normal Office Hours

- **During Normal Office Hours.** You may refer a patient to an urgent care clinic during normal office hours only if the PCP is unavailable, and a triage nurse has determined that the patient requires urgent care, **not hospital emergency care**. The PCP's nursing staff should triage the patient or refer to the Nurse Advice Line if the PCP's nursing staff is unavailable.
- **Requirements for Scheduling Appointments/Referrals to the Urgent Care Clinic.** When referring a CHIP 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 CHIP 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 CHIP Member will be admitted to the nearest hospital emergency department appropriate for the patient's condition. If a **medical emergency does not exist,** but the examining Physician determines that hospitalization is necessary for further evaluation or treatment, the PCP will be contacted to affirm concurrence in admitting the patient. It will then be the PCP's responsibility to arrange admission to a Community First network hospital.

Routine/Non-Emergent Condition

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

2. EMERGENCY TRANSPORTATION

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

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

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction,

or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria.

Emergency transports do not require prior authorization.

3. MEMBER/CLIENT ACKNOWLEDGMENT STATEMENT

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

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

- The patient requests the specific service
- The Provider obtains and keeps a Member/Client Acknowledgment Statement signed by the patient and the Provider

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 sonrazonables ni médicamente necesarios para mi salud."

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

- Any service that is not a benefit of the Texas CHIP Program (e.g., personal care items).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for THSteps-eligible clients younger than age 21 years.
- All services provided as a private pay patient. If the Provider accepts the client as a private pay patient, the Provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying

for all services received. In this situation, HHSC strongly encourages the Provider to ensure that the client signs written notification so there is no question how the client was accepted.

4. PRIVATE PAY FORM AGREEMENT

A participating Physician or Provider may bill a CHIP Member only if:

- A specific service or item is provided at the CHIP Member's request
- The Provider has obtained and kept a written Private Pay Agreement Form signed by the client. This form is available on our website at CommunityFirstMedicaid.com.

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 Form from the CHIP Member. Without written, signed documentation that the CHIP Member was properly notified of the private pay status, the PCP or participating Provider cannot seek payment from an eligible CHIP Member.

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

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

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

5. EMERGENCY PRESCRIPTION SUPPLY

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

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

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

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

6. EMERGENCY AND NON-EMERGENCY DENTAL SERVICES

Emergency Dental Services

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

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

Non-Emergency Dental Services

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

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

F. PROVIDER RESPONSIBILITIES

1. PRIMARY CARE PROVIDER (MEDICAL HOME) RESPONSIBILITIES

Primary Care Providers (PCP) function as the Medical Home for Community First CHIP Members.

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 Primary Care Provider practice or, if appropriate, a Specialty Care Provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management focused on improving outcome-based quality of care and increasing patient and Provider satisfaction under Medicaid. The role of the Health Home is to provide Members with multiple chronic physical and emotional conditions with a team-based approach to care while covering a holistic array of services and supports extending beyond what can be provided by the Member's PCP. Health Homes operate in conjunction with two other entities: a Primary Care practice, and/or a Specialty Care practice. Health Homes are designed to provide easy access to care between Providers while ensuring quality of care continues.

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).

Health homes must provide six core services:

1. Patient self-management education
2. Provider education
3. Evidence-based models and minimum standards of care
4. Patient-centered and family-centered care
5. Patient and family support (including authorized representatives)
6. Service Coordination

Provider Rights

1. To be treated by their patients, who are Community First Members, and other health care workers with dignity and respect.
2. To receive accurate and complete information and medical histories for Members' care.
3. To have their patients, who are Community First Members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
4. To expect other Network Providers to act as partners in Members' treatment plans.
5. To expect Members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Community First and/or a Member.
7. To file a grievance on behalf of a Member, with the Member's consent.
8. To have access to information about Community First quality improvement programs, including program goals, processes, and outcomes that relate to Member care and services.
9. To contact Provider Services with any questions, comments, or problems.
10. To collaborate with other health care professionals who are involved in the care of Members.
11. To not be excluded, penalized, or terminated from participating with Community First for having developed or accumulated a substantial number of patients in Community First with high-cost medical conditions.
12. To collect Member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below:

- Provide Community First's Members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Community First's clinical and non-clinical guidelines, and within the practice of their professional license.
- Abide by the terms of your Community First Provider Participation Agreement.
- Comply with all of Community First's policies, procedures, rules, and regulations, including those found in this Provider Manual.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within the Community First network.

- Verify Member eligibility for authorizations or services.
- Ensure Member understands their right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Community First medical records guidelines and as applicable to HIPAA regulations.

PLEASE NOTE: Provider agrees that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization, available through portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

- Maintain a facility that promotes patient safety.
- Participate in Community First's Quality Improvement program initiatives.
- Participate in Provider orientations and continuing education.
- Abide by the ethical principles of their profession.
- Notify Community First if the Provider is undergoing an investigation or has agreed to written orders by the state licensing agency.
- Notify Community First if a Member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in the amounts that meet Community First credentialing requirements and/or state-mandated requirements.
- Notify Community First if there is a change in office address, tax ID number, or any other demographic changes.
- Inform Members on how to report abuse, neglect, and exploitation.
- Train staff on how to recognize and report abuse, neglect, and exploitation.
- Maintain enrollment status with Texas Medicaid.
- Comply with the requirements of Texas Government Code §531.024161 regarding the submission of claims involving supervised Providers.
- Maintain the Participating Provider Conflict of Interest and Health Care Entity Financial Interest Policy and Disclosure statements to reflect current status. Further details about the designees and types of requests can be found within Network Provider contracts.
- Provide, at no cost to HHSC or its delegates, any requested records in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

PLEASE NOTE: Texas Medicaid will deny claims for prescriptions, items, and services ordered, referred or prescribed, for any Medicaid or Healthy Texas Women Member when the Provider who ordered, referred, or prescribed the items or services is not enrolled in Texas Medicaid. This applies to both In-State and Out-of-State Providers

Integrating Physical Health/Behavioral Health in Medical 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 arranging and coordinating appropriate referrals to other Providers and specialists within the network, 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.
- A PCP is required to refer a Member to a specialist when medically necessary care is needed beyond the scope of the PCP.
- A Member should be referred to a specialist by their PCP.
- A specialist cannot refer to another specialist. All Member care should be coordinated through the PCP.
- PCPs are required to request authorization for services requiring authorization.
- PCPs must document the coordination of referrals and services provided between the PCP and specialist. PCPs are responsible for the appropriate coordination and referral of Community First CHIP Members for the following services:
  - CPW Case Management Services
  - ECI Case Management Services
  - MR Targeted Case Management
  - Texas Commission for the Blind Case Management Services
  - Tuberculosis services
  - Community First's pharmacy program through Navitus

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

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

2. AVAILABILITY AND ACCESSIBILITY

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

Acceptable Phone Arrangements

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

Unacceptable Phone Arrangements

A. The office phone is only answered during office hours.
B. The office phone is answered after hours by a recording, which tells patients to leave a message.
C. The office phone is answered after hours by a recording, which directs patients to go to an emergency department for any services needed.
D. The answering machine is not bilingual (English and Spanish).
E. Returning after-hours calls outside of 30 minutes.

NOTE: If after hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Updates to Contact Information

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

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 management of medical concerns.

The following standards are established regarding appointment availability:

- A full-time practice is defined as one where the Provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- Emergency services must be provided upon the Member's presentation at the service delivery site, including at non-network and out-of-area facilities.
- Urgent care, including urgent specialty care, must be provided within 24 hours.
- Routine primary care must be provided within 14 days.
- Initial outpatient behavioral health visits must be provided within 14 days.
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the Member's medical condition, but no later than five days.
- Prenatal care must be provided within 14 days, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists.
- Preventive health services for adults must be offered within 90 days of the request.

NOTE: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare Members.

Type of Care	Example	Appointment Availability	Primary Provider Type
"Emergency Care" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in: • Death, placing the Member's health in serious jeopardy, permanent impairment of bodily functions, or serious dysfunction of any bodily organ or part. • With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.	Radiating chest pain, severe shortness of breath.	Services must be provided upon Member presentation at the service delivery site.	PCP, Specialist, Hospital
"Urgent Care" is defined as 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 their condition requires medical evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health. "Urgent Behavioral Health Situation" is defined as a behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to themselves or others, and the Member is able to cooperate with treatment.	Fever, persistent vomiting, wants to hurt or has thoughts about hurting themselves or others.	Appointment must be offered within 24 hours of the request, including urgent specialty care.	PCP, Specialist

Type of Care	Example	Appointment Availability	Primary Provider Type
"Routine Primary Care" is defined as health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.	Services designed to prevent disease, to detect disease and treat early, or to manage the course of disease effectively.	Within 14 days of request.	PCP
Routine Specialty Care.	Referral for non-urgent condition.	Within 21 days of request.	Specialist
Preventive Health Services for Adults.	Annual physical, well women examination.	Within 90 days of request	PCP, Gynecologist
Prenatal Care.	Routine prenatal care visits.	Within 14 days of request.	Obstetrical Services Providers
High-risk pregnancy or new Member in the third trimester.	Bleeding, no previous prenatal care.	Within 5 days of request or immediately if an emergency exists.	Obstetrical Services Providers
Routine Initial Visits and Follow-Up Behavioral Health Care.	Acute/chronic psychiatric and substance use disorders.	Within 14 days of request.	Behavioral Health Care Provider, Psychologist

Covering Providers. PCPs must arrange for coverage with another Community First contracted Provider during scheduled or unscheduled time off. Covering Providers must have an active National Provider Identifier (NPI) number in order to receive payment. For provision of services to Medicaid Members, Providers must also be actively enrolled in Texas Medicaid.

Member Education. Community First abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services for our Members. Materials are also made available in large print, braille, and on CD when requested. A variety of sources are used to inform Community First Members, in a culturally sensitive manner, about the health plan and the services available to them. This includes, but is not limited to:

- Member Handbooks
- Member biannual newsletter

- Member monthly e-newsletters
- Targeted Disease Management brochures
- Provider Directories
- Community First website
- Special mailings

3. PLAN TERMINATION PROCESS

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

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

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

A. Imminent harm to patient health
B. An action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency, that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession
C. Fraud or malfeasance

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

Termination for Gifts or Gratuities

Providers may not offer or give anything of value to an officer or employee of HHSC or the state of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term

does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and federal law. Community First may terminate the Provider contract at any time for violation of this requirement.

4. MEMBER'S RIGHT TO DESIGNATE AN OB/GYN

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

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

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

5. OPTOMETRY AND OPHTHALMOLOGY SERVICES

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

6. ACCESS TO MEDICATION

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

7. HOW TO HELP A MEMBER FIND DENTAL CARE

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

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

8. ADVANCE DIRECTIVES

The Provider must comply with the requirements of state and federal laws, rules, and regulations relating to advance directives. Providers must inform Members, 18 years of age and older, of their right to refuse, withhold, or withdraw medical and mental treatment, and the rights of the Member or Member's representative to facilitate medical care or make treatment decisions when the Member is unable to do so as stipulated in the Advance Directives Act, Chapter 166, Texas Health and Safety Code.

It's the Member's right to accept or refuse medical care. An Advance Directive can protect this right if they ever become mentally or physically unable to choose or communicate their wishes due to an injury or illness. To request additional information or to request a brochure about advance directives, the Member can contact Member Services at **210-358-6403** or toll-free at **1-855-607-7827**.

9. REFERRAL TO SPECIALISTS AND HEALTH-RELATED SERVICES

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

10. PCP AND BEHAVIORAL HEALTH RELATED SERVICES

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

11. REFERRAL TO NETWORK FACILITIES AND CONTRACTORS

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

Community First requires preauthorization for court mandated inpatient psychiatric care for CHIP Members. Community First will not, however, deny, reduce, or controvert the medical necessity of any physical or behavioral health care services included in an order entered by the court with respect to a child in the conservatorship of the Texas Department of Child Protective Services.

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

12. ACCESS TO A SECOND OPINION

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any participant in the Member's health care team, including the Member, parent, and/or guardian, or a social worker exercising a custodial responsibility.

Authorization for a second opinion will be granted to a Network Provider or an out-of-Network Provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the Member.

If the Provider who will see the Member for a second opinion is not in-network, an authorization is required.

13. SPECIALTY CARE PROVIDER RESPONSIBILITIES

Availability and Accessibility

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

Acceptable Phone Arrangements

A. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and who can contact the specialist or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
B. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient to call another number to reach the specialist or another Network Provider designated by the specialist. Someone must be available to answer the designated Network Provider's phone. A second recorded message is not acceptable.
C. Office phone is transferred after hours to another location where someone will answer the phone and be able to contact the specialist or another designated Network Provider.

Unacceptable Phone Arrangements

A. The office phone is only answered during office hours.
B. The office phone is answered after hours by a recording, which tells patients to leave a message.
C. The office phone is answered after hours by a recording, which directs patients to go to an emergency department 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 Specialist as a Primary Care Provider in the Introduction section 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
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 in-patient 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.
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)

ACCESS STANDARDS	
Appointment Type	**Appointment Availability**
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

14. VERIFYING MEMBER ELIGIBILITY AND AUTHORIZATION FOR SERVICES

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

Each CHIP Member is issued a Your Texas Benefits Medicaid Card and a plan (i.e., Community First) ID card. We instruct the CHIP Member to present both ID cards when requesting services. The Community First Member ID card shows 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 CHIP 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, log on to the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal or call Member Services at **1-855-607-7827**.

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 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 ID card (for non-dual Members). Listed below are helpful ways to verify eligibility:

- Call Member Services at **210-358-6030** or **1-800-434-2347**
- Visit CommunityFirstMedicaid.com and log into the Provider Portal
- Review the temporary ID (Form 1027A), which is issued when the Member's Texas Benefits Card is lost or stolen, or temporary emergency Medicaid is granted.
- Call the AIS Line at **512-345-5949** or **1-855-607-7827**

If a Member has questions about benefits or coverage or wants to change their PCP, please ask them to call Member Services at **210-358-6030**.

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

- **Inpatient admissions prior to enrollment with Community First**. Community First is responsible for Physician and non-hospital services from the date of enrollment with Community First. Additionally, Community First is not responsible for any hospital charges for Members admitted prior to enrollment with Community First.
- **Inpatient admissions after enrollment with Community First.** Community First is responsible for services until they discharge the CHIP Member from the hospital unless the Member loses CHIP eligibility.
- **Discharge after voluntary disenrollment from Community First and re-enrollment into a new CHIP HMO.** Community First remains responsible for hospital charges until the CHIP Member is discharged from the facility. The new CHIP HMO is responsible for Physician and non-hospital charges beginning on the effective date of enrollment into the new CHIP HMO.
- **CHIP Perinate Newborns.** Community First is responsible for all covered services related to the care of a CHIP Perinate Newborn child from the date of birth if the mother is enrolled with the Community First Perinate program at the time of birth.
- **Hospital Transfers.** Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment should not be considered as discharged under this section.
- **Psychiatric Care.** Inpatient psychiatric care, in a freestanding psychiatric facility for CHIP Members under age 19, is Community First's responsibility from the Member's date of enrollment with Community First.

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

The PCP is responsible for initiating all referrals to Specialty Care Providers (see section on Referral Notification).

Community First currently requires preauthorization for services listed on the authorization list at Medicaid.CommunityFirstHealthPlans.com/Provider-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: Preauthorizations are generally valid for 30 days from the date issued. This timeframe may be extended based on the type of request. Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If preauthorization expires, call Community First.

All services listed on the preauthorization list will be subject to a medical necessity review in advance of the services being rendered. Failure to obtain preauthorization in

advance of the service being rendered will result in an administrative denial of the claim. Providers cannot bill CHIP Members for covered services.

PCPs and specialists may request preauthorization as follows:

- Call Community First's Population Health Management Department at **210-358-6050**.
- Fax the completed Texas Standard Prior Authorization Request for Health Care Services Form to **210-358-6040**.
- Submit secure electronic requests using the Provider Portal. (Contact Community First Provider Relations at **210-358-6294** or email ProviderRelations@cfhp.com for help registering.)

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

Please have the following information available when requesting preauthorization:

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

Population Health Management will issue an authorization number for approved requests after eligibility, medical necessity, and benefit criteria has been determined. Faxed requests will be faxed back to the requesting Provider including the authorization number if the service(s) has been approved. Telephone requests will receive an authorization telephonically if the service(s) is approved.

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

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

decision on behalf of the Member. Appeal information will be included in the denial letter.

15. CONTINUITY OF CARE

Continuity of Care for Pregnant Women

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

Continuity of Care for Members that Move Out of Service Area

Community First will reimburse Out-of-Network Providers for covered services rendered to CHIP Members who move out of Community First's service area through the end of the period for which a premium has been paid for the Member.

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

Continuity of Care for Pre-Existing Conditions

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

16. TRANSITION OF CARE

A transition in care for a Member is defined as a point at which the Member's care is transferred from one Provider to another or from a facility to another level of care. Examples of transitions in care include the following:

- A referral from a PCP to a specialist.
- An admission to a hospital or a discharge from a hospital to home care or a skilled nursing facility.

When a Member experiences a transition in care, it is the responsibility of the transferring Provider to do the following:

- Notify the Member in advance of a planned transition.
- Provide documentation of the care plan to the receiving institution or Provider within 24 hours of the transition.
- Communicate with the Member about the transition process.
- Communicate with the Member about their health status and plan of care.

- Notify the Member's usual practitioner of the transition within three (3) business days after notification of the transition.
- Provide a treatment plan/discharge instructions to the Member prior to discharge.
- Notify the Member's Community First Service Coordinator.

The Provider is an integral part of effectively managing transitions. Communication is the key with both the Member and other Treating Providers. To prevent duplicate testing and provide critical information about the Member, the following processes should be followed:

- The referring Physician or Provider should provide the relevant patient history to the receiving Provider.
- Any pertinent diagnostic results should be forwarded to the receiving Provider.
- The receiving Provider should communicate a treatment plan back to the referring Provider.
- Any diagnostic test results ordered by the receiving Provider should be communicated to the referring Provider.

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

17. JUSTIFICATION FOR OUT-OF-NETWORK AUTHORIZATIONS

Community First's requirements concerning treatment of Members by Out-of-Network Providers are as follows:

A. Community First will allow referral of its Member(s) to an Out-of-Network Provider, issue the proper authorization for such referral in a timely manner, and timely reimburse the Out-of-Network Provider for authorized services provided when:
   - CHIP-covered services are medically necessary, and these services are not available through an In-Network Provider.
   - A Provider currently providing authorized services to the Member requests authorization for such services by an Out-of-Network Provider.
   - The authorized services are provided within the time period specified in the authorization issued by Community First. If the services are not provided within the required time period, a new request for preauthorization from the requesting Provider must be submitted to Community First prior to the provision of services.

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

C. Community First's requirements concerning emergency services are as follows:
   - Community First must allow its Members to be treated by any Emergency Services Provider for emergency services or for services to determine if an emergency condition exists.
   - Community First is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

D. Community First may be required by contract with HHSC to allow Members to obtain services from Out-of-Network Providers in circumstances other than those described above.

Reasonable Reimbursement Methodology

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

- For a date of service on or after February 20, 2010 Out-of-Network/In-Area Providers were reimbursed at CHIP minus 5% in accordance with the change in Texas Administrative Code (TAC) at Title 1, Part 15, Chapter 355.
- Out-of-Network/Out-of-Area Providers requesting reimbursement at 100% of CHIP rates are considered if a timely request for authorization is obtained, which includes the requirement to request 100% of the CHIP rate at the time of the request for authorization. If the service(s) are approved, the request for the 100% CHIP rate will be forwarded to Provider Relations to address the requested rate with the Provider.

18. COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

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

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

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

The Provider must coordinate with DFPS and the Member 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.

G. MEMBER ELIGIBILITY AND ENROLLMENT

1. MEMBER ELIGIBILITY

HHSC and Centers for Medicare and Medicaid Services (CMS) are responsible for determining CHIP eligibility. The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the CHIP program. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at **1-800-964-2777**.

When a Member gains eligibility, the state's Enrollment Broker sends the Member an enrollment packet informing the Member of the health plan choices in their area. The packet will also inform the Member to select a health plan and a PCP within 15 days.

Member eligibility guidelines are as follows:

- 12-month eligibility for CHIP Program Members
- A CHIP Perinate Newborn who lives in a family with an income at or below the Medicaid Eligibility Threshold of the Federal Poverty Level (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn will continue to receive coverage through the CHIP Program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid Eligibility Threshold of the Federal Poverty Level and the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in their CHIP Perinate health plan.

These determinations are made by HHSC.

Verifying Eligibility

Each CHIP Member is issued a Texas Benefits Medicaid and a health plan (i.e., Community First) ID Card. However, having a card does not always mean the Member has current coverage. We instruct the CHIP Members to present both ID Cards when requesting medical services. It is imperative that Providers verify the Member'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 TMHP.com.
- Call Provider Services at the patient's medical or dental plan.

The Community First ID Card shows important Member information such as Community First's telephone numbers and the Member's assigned PCP. Providers may contact Community First to verify Member eligibility by calling **210-358-6030** or **1-800-434-2347**.

If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the primary care Provider's name, address, and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through Community First.

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

Pregnant Teens

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

Span of Eligibility

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

2. MEMBER ENROLLMENT, RE-ENROLLMENT, AND DISENROLLMENT

Enrollment (12-Month Eligibility)

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

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

Newborn Enrollment Process

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

- The end of the CHIP Perinate Newborn Member's enrollment period; or
- The end of the traditional CHIP Program Member's enrollment period

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

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

Re-Enrollment

At the beginning of the fifth (5th) month of coverage, the HHSC will send a note to the family outlining the next steps for renewal or continuation of coverage. HHSC also will send a notice to Community First regarding its Members and to a community-based outreach organization providing follow-up assistance in the Members' area. To promote the continuity of care for children eligible for re-enrollment, Community First may

facilitate re-enrollment through reminders to Members and other appropriate means. Failure of the family to respond to the HHSC's renewal notice will result in disenrollment from Community First and from CHIP/CHIP Perinate Program.

3. PROVIDERS FOR MEMBERS WITH DISABILITIES, CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN), AND CHRONIC/COMPLEX CONDITIONS

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

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

A. Certification by the Non-Primary Care Provider specialist as a PCP.
B. A signed statement by the Non-Primary Care Provider specialist that they are willing to accept responsibility for the coordination of all the Member's health care needs including referrals to other specialists.
C. The signature of the Member's guardian concurring with the request.

Disenrollment

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

- "Aging-out" when a child turns 19
- Change in health insurance status, such as a child enrolling in an employer-sponsored health plan
- Failure to meet the monthly cost sharing obligation
- Death of a child
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP/CHIP Perinate
- Immigration
- Increased income
- Provisional eligibility term
- Health plan change
- No longer CHIP/CHIP Perinate-eligible
- Child left household

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

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

- The CHIP Member misuses or lends their Community First Member ID card to another person to obtain services.
- The CHIP Member is disruptive, unruly, threatening, or uncooperative to the extent that the CHIP Member seriously impairs Community First's or a Provider's ability to service the CHIP Member. However, this only occurs if the CHIP Member's behavior is not due to a physical or behavioral health condition.
- The CHIP Member steadfastly refuses to comply with managed care, such as repeated emergency department 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 a Member. The Member's disenrollment request will require medical documentation from the PCP or documentation that indicated sufficiently compelling circumstances that merit disenrollment.

Plan Changes

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

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

H. SPECIAL ACCESS REQUIREMENTS

1. INTERPRETER/TRANSLATION SERVICES

Community First has interpretive services available for its CHIP Members to ensure effective communication regarding treatment, medical history, or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide CHIP Members access to professionals trained to help with technical, medical, or treatment information.

To arrange for a sign interpreter or language interpreter for a Community First CHIP Member, please contact Community First Member Services at **210-358-6030**.

Community First is committed to ensuring that staff and subcontractors are educated about, remain aware of and are sensitive to the linguistic needs and cultural differences of our membership. Information about cultural and linguistic competency and interpreter and translation services are included in a variety of communications media via this Provider Manual, the Community First Provider Newsletter, and the Community First Provider Portal.

Providers are also informed of their ability to request assistance with professional interpreter and translation services with the utilization of Community First's interpreter and translation partners, 24-Hour Nurse Advice Line, and Telephone Interpreter Services Vendors to assist with Community First's membership when language or hearing impairment is a barrier to communication.

2. COMMUNITY FIRST AND PROVIDER COORDINATION

Community First will make every effort to communicate with and coordinate the delivery of covered services with a CHIP Member's PCP. Community First will provide each PCP and their 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 an assigned Provider Relations representative to answer any questions or concerns and to review critical elements with the Physician and their staff.

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

3. READING/GRADE LEVEL CONSIDERATION

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

4. CULTURAL SENSITIVITY

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

5. CHILDREN WITH COMPLEX AND SPECIAL HEALTH CARE NEEDS

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

Any interested person may initiate the request to Community First for a specialist to serve as a CHIP Member who is disabled, has Special Health Care Needs, or a Chronic or Complex Condition. Community First shall handle the request as outlined in its policy (Specialist Physician as Primary Care Physician, # 500.17) which is in compliance with 28.TAC Part 1, Chapter11, Subchapter J.

I. CHIP MEMBER RIGHTS AND RESPONSIBILITIES

1. CHIP MEMBER RIGHTS

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.
   c. Be given information about your health, plan, services, and Providers.
   d. Be told about your rights and responsibilities.
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 Reviews 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. DBMD escalation help line for Members receiving Waiver services via the Deaf/Blind Multi-Disability Program.
   c. Get a timely answer to your complaint.
   d. Use Community First's appeal process and be told how to use it.
   e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive 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.
9. 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.
10. Members have the right to make recommendations about Community First's Member Rights and Responsibilities Policies.

2. CHIP MEMBER RESPONSIBILITIES

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

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 department.

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.
5. You can ask for and get the following information each year:
   - Information about Community First and our Network Providers at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of Providers that are not accepting new patients, and qualifications for each Network Provider such as:
     a. Professional qualifications
     b. Specialty
     c. Medical school attended
     d. Residency completion
     e. Board certification status
     f. Provider demographics
   - Any limits on the Member's freedom of choice among Network Providers.
   - Member rights and responsibilities.
   - Information on complaint, appeal, and State Fair Hearing procedures.
   - Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits. This is designed to make sure Members understand the benefits to which they are entitled.
   - How Members can get benefits, including authorization requirements and family planning services, from Out-of-Network Providers and/or limits to those benefits.
   - How Members get after hours and emergency coverage and/or limits to those kinds of benefits, including:
     a. What makes up emergency medical conditions, emergency services, and post stabilization services.
     b. The fact that Members do not need prior authorization from their PCP for emergency care services.
     c. How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
     d. The addresses of any places where Providers and hospitals furnish emergency services covered by Medicaid.

e. A statement saying the Member has the right to use any hospital or other settings for emergency care.
f. Post-stabilization rules.

- Policy on referrals for specialty care and for other benefits a Member cannot get through their PCP.
- Community First's practice guidelines.

J. PREVENTIVE HEALTH AND DISEASE MANAGEMENT

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

Provider Referral

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

Mail in the Member Education Request Form to the following address:

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

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

Community First New Member Assessment Program

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

Health Education Services

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

1. DIABETES IN CONTROL: DIABETES MANAGEMENT PROGRAM

Per the CDC's National Diabetes Statistics Report of 2023, (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 program's goals include identification of Members with diabetes, increasing awareness and understanding of diabetes, increasing risk reduction behaviors, improving access to quality diabetes education and health care services, and promoting diabetes standards of care in coordination with the Texas Diabetes Council's Minimum Standards for Diabetes Care in Texas.

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

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

2. ASTHMA MATTERS: ASTHMA MANAGEMENT PROGRAM

Asthma Matters: Asthma Management Program is an initiative developed by Community First to improve the health, well-being, and productivity of our Members

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

The **Asthma Matters** program targets Members identified as having asthma via pharmacy management records, claim and encounter utilization data, and information received via the completion of Member health surveys. Utilization patterns are routinely assessed and targeted interventions are implemented to coordinate health care delivery and measures to improve Members' clinical, quality of life, and economic status. Clinical outcomes may include a decrease in the use of beta-agonists, an increase in use of asthma-controlling medications, and an increase in the number of outpatient visits. Improvement in quality-of-life factors may include increased productivity and activity without asthma episodes, decreased absences from work or school, sleeping through the night without asthma episodes, increased knowledge about the disease, and overall asthma control with a decrease in acute asthma episodes. Economic outcome measures include decreased hospital admissions, emergency department events, and 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 Matter**s participants are sent an asthma health risk appraisal form. Key areas assessed include current symptoms, treatment protocols, and perception of quality of life. Upon receipt of the survey, Members are stratified into one of three risk categories: low, moderate, and high risk. For each risk category, health promotion outreach activities include:

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

Asthma education is coordinated with existing community education programs to promote utilization of services currently available. Members who are categorized in the moderate risk category are mailed a roster of up-to-date classes available in the community. Follow-up calls are conducted for Members who continue to accrue potentially preventable utilization of the emergency department 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 be involved in their asthma management in collaboration with their Physician. As part of the initiative, the PCP receives a copy of the Members' health assessment tool with a summary of the assigned risk status and educational outreach Community First has initiated for each Member. Information regarding home assessment and education is also sent to the PCP for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data receive utilization and pharmacy profiles for inclusion in Member's medical record.

3. HEALTHY EXPECTATIONS MATERNITY PROGRAM

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

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

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

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

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

An assessment program for identified pregnant women provides an opportunity to identify risk factors. Social and behavioral health education and referral are typical outcome strategies at the initial assessment phase. When completed, the risk tool allows staff time to reach out to those at increased risk for complications. Those at lower risk are sent educational materials and encouraged to attend community-sponsored prenatal

education classes. Pregnant Members who elect to enroll into the program are routinely reassessed at 20-24 weeks gestation to evaluate for changes in prenatal health.

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

4. HEALTHY MIND: BEHAVIORAL HEALTH PROGRAM

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

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

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

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 benefiting Providers to foster continued improvement
- Advocating for each Member's needs and goals by understanding and respecting the Member's value system while searching for necessary funding, appropriate treatment, and treatment alternatives
- Integrating medical and behavioral components of treatment to produce long-lasting results

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

5. HEALTHY LIVING: HEALTHY LIFESTYLE MANAGEMENT PROGRAM

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

The 2019 Bexar County Community Health Assessment Report reflected:

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

Members enrolled in 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.

6. HEALTHY HEART: BLOOD PRESSURE MANAGEMENT PROGRAM

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

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

associated with high blood pressure that include age, family history, race, ethnicity, sex, and an unhealthy lifestyle.

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

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

Members enrolled in **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.

II. CHIP PERINATE PROGRAM FOR PREGNANT WOMEN

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

A. INTRODUCTION

1. BACKGROUND AND OBJECTIVES OF PROGRAM

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

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

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

2. IMPORTANT CHANGES IN APPLICATION PROCESS FOR EMERGENCY MEDICAID

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

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

Currently, women in this income range must fill out an application for Emergency Medicaid to cover their hospital labor with delivery fees. This can cause a problem for the hospital if the mother has new income that puts her over the Medicaid limit. The expectant mother will receive this form along with her CHIP perinatal enrollment packet. HHSC will send another copy of the form a month before the baby's due date in a mailing that includes the letter to remind the expectant mother to send HHSC information about the birth of her child. The woman will be instructed to take Form H3038 to her Provider to fill out the form and then mail the form back to HHSC in a pre-addressed, postage-paid envelope. In most cases, this activity happens after delivery when the mother is discharged from the hospital.

Key Points

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

3. ROLE OF CHIP PERINATAL PROVIDER

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

Network Limitations

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

4. ROLE OF PHARMACY AND PHARMACY PROVIDER

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

- Adhering to the Formulary and Preferred Drug List (PDL).
- Coordinating with the prescribing Physician.
- Ensuring Members receive all medications for which they are eligible.
- Coordinating benefits when a Member also receives Medicare Part D services or other insurance benefits.

B. CHIP PERINATE COVERED SERVICES

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

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

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

1. CHIP PERINATE SCHEDULE OF BENEFITS

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

COVERED SERVICE	LIMITATIONS
Comprehensive Outpatient Hospital, Clinic (including Health Center), and Ambulatory Health Care Center Services include the following services provided in a hospital clinic or emergency department, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to, dilation and curettage (D&C) procedures, appropriate Provider-administered medications, ultrasounds, and histological examination of tissue samples.	**May require prior authorization** and Physician prescription. Laboratory and radiological services are limited to services that directly relate to antepartum care and the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Cordocentesis are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: non-stress testing, contraction stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy, or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by a medical condition of the client.
Comprehensive Outpatient Hospital, Clinic (including Health Center), and Ambulatory Health Care Center	Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.

COVERED SERVICE	LIMITATIONS
Physician/Physician Extender Professional Services Services include, but are not limited to, the following: • Medically necessary Physician services (limited to prenatal and postpartum care and the delivery of the covered unborn child until birth) • Physician office visits, inpatient, and outpatient services • Laboratory, x-rays, imaging, and pathology services, including technical component and professional interpretation • Medically necessary medications, biologicals, and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth ◦ Administration of anesthesia by Physician (other than surgeon) or CRNA ◦ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child ◦ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to, dilation and curettage (D&C) procedures, appropriate Provider-administered medications, ultrasounds, and histological examination of tissue samples.	**May require authorization** for specialty services. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.

COVERED SERVICE	LIMITATIONS
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • (1) One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • Laboratory tests (urinalysis for protein and glucose every visit) • Hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy • Multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy • Repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated • Screen for gestational diabetes at 24-28 weeks of pregnancy • Other lab tests as indicated by medical condition of client

COVERED SERVICE	LIMITATIONS
Prenatal Care and Pre-Pregnancy Family Services and Supplies Covered services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary.	**Does not require prior authorization.** Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the Physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status); physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. Emergency services based on prudent layperson definition of emergency health condition. Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. Stabilization services related to the labor and delivery of the covered unborn child. Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

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

Breast Pump Coverage in Medicaid and CHIP

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

Pregnancy and Postpartum Coverage			
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.

Pregnancy and Postpartum Coverage			
Coverage in prenatal period	**Coverage at delivery**	**Coverage for newborn**	**Breast pump coverage and billing**
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is approved for 12 months of Medicaid coverage, beginning on the date of birth.

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

2. EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES (UNBORN)

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

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

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

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

3. CHIP PERINATE EXTRA BENEFITS (VALUE-ADDED SERVICES)

CHIP Perinate Value-Added Services	Limits and Restrictions
Extra Help for Pregnant Women who participate in Healthy Expectations Maternity Program, including:	

• Mommy & Me Baby Shower
  ○ Free baby car seat or Pack & Play portable play yard
  ○ Free diaper bag with baby supplies, including baby wipes and other baby items
  ○ Free gifts for partners who attend Mommy & Me Baby Shower with mom
	Limited to one baby shower per pregnancy, unless having more than one baby (i.e., twins). Members will receive one diaper bag and a choice of a car seat or safe sleep pack and play.

• Opportunity to participate in the Maternal Community Health Club, a club created for pregnant women to come together and support one another while learning about pregnancy health and infant development For pregnant Members who participate in both Healthy Expectations and the Maternal Community Health Club:
  ○ A Health Educator assigned to you to help find health services, community resources, and guide you through pregnancy and beyond
  ○ Pregnancy, birthing, postpartum, and baby education
  ○ Free baby car seat or Pack & Play portable play yard, whichever was not received the Mommy & Me Baby Shower
• 4th Trimester classes on newborn care, breastfeeding, and car seat safety
	The Maternal Community Health Club is limited to pregnant Members who are also in the Healthy Expectations program.

Home visits for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations	Home visits are contingent upon medical necessity determinations and vary from Member to Member.
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or hard of hearing can call 711.	

CHIP Perinate Value-Added Services	Limits and Restrictions
Extra Help Getting a Ride (bus passes) for Members, their siblings, and their parents or legal guardians to places, such as: • The grocery store • Community-based services • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices • Community offices that help find employment and housing • Social Security Administration-approved Physician for appointments requested for disability determination and services	Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. For nonmedical related use only. This service is available only for bus service routes within San Antonio and routes are offered by VIA Metropolitan Transit.
Gift Programs, including: Up to $150 for pregnant Members participating in Healthy Expectations Maternity Program: • $30 for attending Mommy and Me Baby Shower • $30 for completing the Community First maternity assessment and agreeing to receive health education text messages • $30 for completing a prenatal visit • $30 for receiving the flu shot during pregnancy • $30 for completing a postpartum visit between 7 and 84 days after delivery Plus, up to $30 reimbursement for birthing classes or pregnancy-related items, such as a pregnancy pillow • $50 gift card and health and wellness items for caregivers or Members who complete six in-person or virtual National Alliance on Mental Illness (NAMI) Basics classes about supporting a loved one with a mental health condition	Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit. Date of prenatal visit must occur in the first trimester or within 42 days of enrollment with Community First. Date of postpartum visit must occur prior to end of Member eligibility. Community First will reimburse for birthing classes at hospital that the Community First CHIP Perinate Member delivers their baby. Limited to caregivers caring for Members or Members caring for their children, ages 0 through 19, with a diagnosed mental health condition.
Extra Dental Services, including: • Low-cost dental exams, x-rays, and orthodontic	Limited to 10% discount. No maximum benefit amount. For Members ages 21 through 999 and their family members with no dental coverage.
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	

CHIP Perinate Value-Added Services	Limits and Restrictions
Health and Wellness Services • Free, personalized support and the tools and strategies to keep you motivated and help you become tobacco-free by phone or online. Includes coaching, education, activities, and more	
GED Support • GED program to help Members age 18 through 999 earn a GED certificate, plus extra academic and career support to empower Members entering the workforce	Members in the GED program must: • Be legally able to work in the United States. • Have photo identification. • Take all program-related assessments. • Commit to completing the program.

Durable Medical Equipment (DME)

DME is not a covered benefit for CHIP Perinate Members.

C. COORDINATION WITH NON-CHIP PERINATE COVERED SERVICES (NON-CAPITATED SERVICES)

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

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

1. CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

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

CPW Eligibility

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

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

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

To make a referral, call a CPW Case Management Provider in your area. A list of CPW Providers can be found on the DSHS Case Management Website.

Women, Infants, and Children Program (WIC)

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

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

WIC Eligibility

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

All WIC services are free to those who are eligible.

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

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

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

D. OB/GYN RESPONSIBILITIES

1. ACCESS TO OB/GYNs

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

Acceptable Access

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

Unacceptable Access

- The office phone is only answered during office-hours.
- The office phone is answered after-hours by a recording, which tells patients to leave a message.
- The office phone is answered after-hours by a recording which directs patients to go to an emergency department for any services needed.
- The answering machine is not bilingual (English and Spanish).
- Returning after-hours calls outside 30 minutes

NOTE: If after hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

2. AVAILABILITY STANDARDS FOR OB/GYNs

Type of Care	Example	Appointment Availability	Primary Provider Type
"Emergency Care" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in: • Death, placing the Member's health in serious jeopardy, permanent impairment of bodily functions, or serious dysfunction of any bodily organ or part. • With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.	Radiating chest pain, severe shortness of breath.	Services must be provided upon Member presentation at the service delivery site.	PCP, Specialist, Hospital
"Urgent Care" is defined as 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 their condition requires medical evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health. "Urgent Behavioral Health Situation" is defined as a behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to themselves or others, and the Member is able to cooperate with treatment.	Fever, persistent vomiting, wants to hurt or has thoughts about hurting themselves or others.	Appointment must be offered within 24 hours of the request, including urgent specialty care.	PCP, Specialist
"Routine Primary Care" is defined as health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.	Services designed to prevent disease, to detect disease and treat early, or to manage the course of disease effectively.	Within 14 days of request.	PCP
Routine Specialty Care.	Referral for non-urgent condition.	Within 21 days of request.	Specialist

Type of Care	Example	Appointment Availability	Primary Provider Type
Preventive Health Services for Adults.	Annual physical, well women examination.	Within 90 days of request	PCP, Gynecologist
Prenatal Care.	Routine prenatal care visits.	Within 14 days of request.	Obstetrical Services Providers
High-risk pregnancy or new Member in the third trimester.	Bleeding, no previous prenatal care.	Within 5 days of request or immediately if an emergency exists.	Obstetrical Services Providers
Routine Initial Visits and Follow-Up Behavioral Health Care.	Acute/chronic psychiatric and substance use disorders.	Within 14 days of request.	Behavioral Health Care Provider, Psychologist

Verifying Member Eligibility and Benefits

Each Member approved for CHIP benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the Member has current coverage. It is imperative that Providers verify the Member's eligibility for the date of service prior to services being rendered. There are two ways to do this:

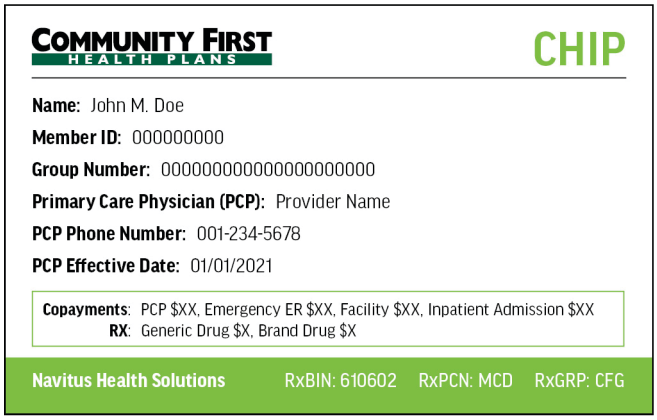
HHSC Resources

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 TMHP.com.
- Call Provider Services at the patient's medical or dental plan .

Member Identification Card

All CHIP Members will receive a Community First Member identification card. Below are samples of CHIP Member identification cards.


COMMUNITY FIRST HEALTH PLANS

CHIP

Name: John M. Doe

Member ID: 000000000

Group Number: 00000000000000000000

Primary Care Physician (PCP): Provider Name

PCP Phone Number: 001-234-5678

PCP Effective Date: 01/01/2021

Copayments: PCP $XX, Emergency ER $XX, Facility $XX, Inpatient Admission $XX
RX: Generic Drug $X, Brand Drug $X

Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG


Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

AVAILABLE 24 HOURS/7 DAYS A WEEK:

Member Services Department
Toll-Free: 1-800-434-2347

Behavioral Health Services
Toll-Free: 1-877-221-2226

Telecommunication Device for the Deaf
TDD: 711

DISPONIBLE 24 HORAS AL DÍA/7 DÍAS A LA SEMANA:

Departamento de Servicios para Miembros
Gratis: 1-800-434-2347

Servicios de Salud Mental
Gratis: 1-877-221-2226

Dispositivo de telecomunicaciones para sordos
Línea TDD: 711

FOR PROVIDERS

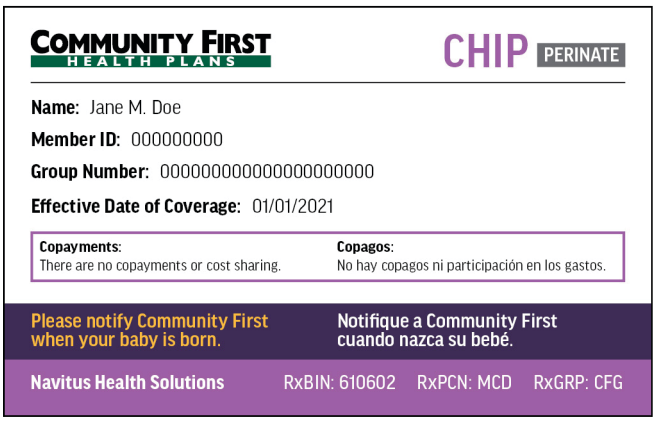
Notice to hospitals and other providers: All inpatient admissions require pre-authorization, except in the case of emergency. Please call Community First within 24 hours at 210-358-6050 or fax to 210-358-6040.

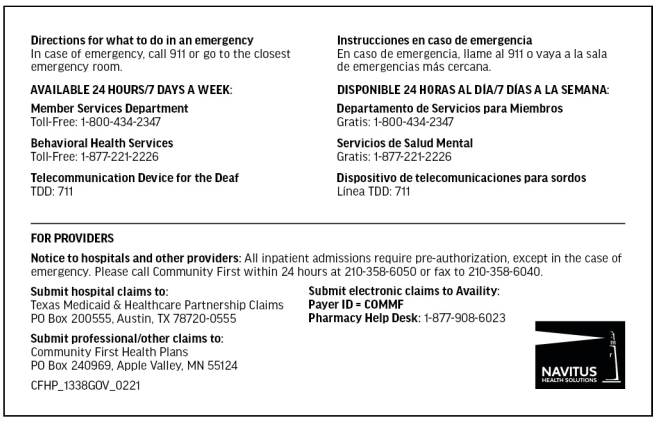
Submit professional/other claims to:
Community First Health Plans
PO Box 240969, Apple Valley, MN 55124

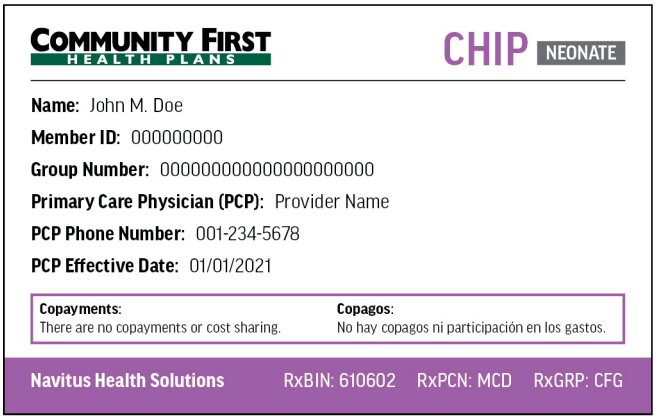
Submit electronic claims to Availity:
Payer ID = COMMF
Pharmacy Help Desk: 1-877-908-6023

CFHP_1337GOV_0221

NAVITUS HEALTH SOLUTIONS







NOTE: Presentation of a Member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

3. 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

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

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

E. PREGNANCY VERIFICATION REQUIREMENTS FOR CHIP PERINATE

Applicants

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

1. Form H3037, Report of Pregnancy; or
2. Any written document containing the same information as Form H3037, including:
   a. Pregnant woman's name
   b. Case name (or head of household, if different)
   c. Month pregnancy began
   d. Number of births expected
   e. Anticipated date of delivery
   f. Signature of Physician, nurse, Advanced Nurse Practitioner, or other medical professional (under Physicians' orders)

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

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

F. MEMBER ELIGIBILITY

1. MEMBER ELIGIBILITY

Each CHIP Member is issued a Your Texas Benefits Medicaid Card and a plan (i.e., Community First) ID card. We instruct the CHIP Member to present both ID cards when requesting services. The Community First Member ID card shows 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 CHIP 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, log on to the secure online Community First Provider Portal at CommunityFirstHealthPlans.com/ProviderPortal or call Member Services at **1-800-434-2347**.

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 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 ID card (for non-dual Members). Listed below are helpful ways to verify eligibility:

- Call Community First Member Services at **210-358-6403** 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 the 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 them to call our Member Services at **1-800-434-2347**.

2. PREGNANCY AND CHIP PERINATE ELIGIBILITY

CHIP Perinate Members

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

CHIP Perinate Newborns

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

3. SPAN OF ELIGIBILITY

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

4. CHIP PERINATE MEMBER PLAN CHANGES

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

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

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

D. A CHIP Perinate Newborn is eligible for 12 months' continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in their CHIP Perinatal Health Plan.
E. CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.
F. When a Member of the household enrolls in a CHIP Perinatal Program, all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if the plan is different. All Members of a household must remain in the same health plan until the latter of:
    - The end of the CHIP Perinate Member's enrollment period.
    - The end of the traditional CHIP Member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP Renewal Form. The family must complete and submit the Renewal Form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to their sibling's existing CHIP case.
G. CHIP Perinatal Members may request to change health plans under the following circumstances:
    - For any reason within 90 days of enrollment in the CHIP Perinatal Program
    - If the Member moves into a different delivery area
    - For cause at any time
    - During the annual re-enrollment period

5. INVOLUNTARY DISENROLLMENT

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

- Change in health insurance status, such as enrolling in an employer-sponsored health plan
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP/CHIP Perinatal
- Immigration
- Increased income
- Provisional eligibility term
- Health plan change
- No longer CHIP/CHIP Perinatal-eligible

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

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

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

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

G. CHIP PERINATE MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

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.
   c. Be given information about your health, plan, services, and Providers.
   d. Be told about your rights and responsibilities.
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 Reviews 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. DBMD escalation help line for Members receiving Waiver services via the Deaf/Blind Multi-Disability Program.
    c. Get a timely answer to your complaint.
    d. Use Community First's appeal process and be told how to use it.
    e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive 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.
9. 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.
10. Members have the right to make recommendations about Community First's Member Rights and Responsibilities Policies.

Member Responsibilities

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

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 department.
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.
5. You can ask for and get the following information each year:
   - Information about Community First and our Network Providers at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of Providers that are not accepting new patients, and qualifications for each Network Provider such as:
     a. Professional qualifications
     b. Specialty
     c. Medical school attended
     d. Residency completion
     e. Board certification status
     f. Provider demographics

- Any limits on the Member's freedom of choice among Network Providers.
- Member rights and responsibilities.
- Information on complaint, appeal, and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits. This is designed to make sure Members understand the benefits to which they are entitled.
- How Members can get benefits, including authorization requirements and family planning services, from Out-of-Network Providers and/or limits to those benefits.
- How Members get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  a. What makes up emergency medical conditions, emergency services, and post stabilization services.
  b. The fact that Members do not need prior authorization from their PCP for emergency care services.
  c. How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  d. The addresses of any places where Providers and hospitals furnish emergency services covered by Medicaid.
  e. A statement saying the Member has the right to use any hospital or other settings for emergency care.
  f. Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits a Member cannot get through their PCP.
- Community First's practice guidelines.

H. HEALTHY EXPECTATIONS MATERNITY PROGRAM

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

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

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

The Population Health Management staff collaborates with Health Plan Providers to offer comprehensive perinatal services, as we believe education is an important factor

in changing behaviors and improving the overall health of our Members. Outreach to pregnant Members includes:

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

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

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

III. REQUIREMENTS AND INFORMATION COMMON TO ALL CHIP PROGRAMS

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

A. LEGAL AND REGULATORY

1. LAW, RULES, AND REGULATIONS

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

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

Environmental Protection Laws

- Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products
- National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514, "Protection and Enhancement of Environmental Quality," relating to the institution of environmental quality control measures
- Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to federal Contracts, Grants, and Loans")
- State Clean Air Implementation Plan (42U.S.C. §740 et seq.) regarding conformity of federal actions to state Implementation Plans under §176(c) of the Clean Air Act
- Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water

State and Federal Anti-Discrimination Laws

- Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794)
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.)
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107)
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688)
- Food Stamp Act of 1977 (7 U.S.C. §200 et seq.)
- Executive Order 13279, and its implementing rules for equal protection of the laws for faith-based organizations

2. LIABILITY

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

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

The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, Community First, its employees, agents, or subhealth plans. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by Community First or any judgment rendered against Community First. HHSC's liability to the Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

3. MEDICAL CONSENT REQUIREMENTS

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

4. MEMBER COMMUNICATION

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

5. REPORTING FRAUD, WASTE, OR ABUSE BY A PROVIDER OR CLIENT

Community First Members, Providers, and others can report fraud, waste, or abuse by following the steps outlined below.

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.
   - Upcoding for services provided to receive higher reimbursement.
   - Unbundling when billing for services provided.
   - 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 they have 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 OIG.HHS.Texas.gov/Report-Fraud-Waste-or-Abuse to complete IG's Fraud Reporting Form
   - Report directly to Community First at:
     Community First Health Plans, Inc.
     Attention: Special Investigations Unit
     12238 Silicon Drive, Suite 100
     San Antonio, TX 78249

- Call Community First Provider Services at **1-855-607-7827** or the Community First Anti-Fraud Hotline at **210-358-6332** (toll-free **1-877-225-7152**)

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 program in which the Member is/was enrolled (STAR+PLUS)
   - 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

Community First Providers can also report Fraud, Waste, or Abuse directly to Community First using our online Suspicious Activity Report forms. Submit the Member and/or Provider Suspicious Activity forms either:

- Online: CommunityFirstHealthPlans.com/Fraud-Waste-Abuse
- Fax: **210-358-6405**
- Email: SIURequest@cfhp.com

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 several activities through its in-house Special Investigation Unit (SIU) to detect, prevent, and eliminate fraud, waste, and abuse at the Provider, recipient, and health plan level to include coding and documentation audits, pre- and post-payment review, verification of services through member outreach, and utilization of claims editing software. Community First trains employees, contractors, 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; prevent future occurrences of fraud, waste, and abuse; and report offenses to the appropriate agencies. The Special Investigation Unit (SIU) follows the requirements

of the Texas Administrative Code §353.505 and §370.505 regarding the recovery of overpayments

Community First considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive, and or attempting to obtain unjust 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

Claims Review and Auditing
Community First utilizes established industry claims adjudications and/or clinical practices, National Correct Coding Initiative Edits (NCCI), State and Federal guidelines, and/or Community First's policies and data to determine the appropriateness of billing, coding, and reimbursement.

The Provider acknowledges Community First's right to conduct prepayment and post payment billing audits. The Provider shall cooperate with Community First's Special Investigation Unit (SIU) and audits of claims and payments by providing requested claims information, including supporting medical records, Provider's charging policies, and other related information or data as deemed applicable to support the services billed.

Providers are required to submit, or provide access to, medical records upon Community First's request. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment. Failure to respond or submit the necessary documentation for the specified claim(s) and date(s) of service(s) may result in recoupment of the claim. An appeal will not be accepted for recoupments or overpayments related to missing medical records or late submissions.

Community First may select a statistically valid random sample, or smaller subset of the statistically valid random sample, depending on the type of audit or monitoring being conducted. This sample gives an estimate of the proportion of claims Community First may have paid in error. The estimated percentage, or error rate, may be projected across all claims to determine the amount of overpayment. Provider audits may be telephonic, an on-site visit, internal claims review, regulatory investigation, and/or compliance reviews.

If Community First's Special Investigation Unit suspects that there is fraudulent or abusive activity, an on-site audit without notice may be conducted. Should the Provider refuse to allow access to their facilities, Community First reserves the right to recover the full amount paid or due to the Provider.

6. REPORTING ABUSE, NEGLECT, AND EXPLOITATION

Report Suspected Abuse, Neglect, and Exploitation (ANE)

Community First and Providers must report any allegation or suspicion of Abuse, Neglect, or Exploitation (ANE) that occurs within the delivery of LTSS to the appropriate entity. The managed care contracts include MCO and Provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and Provider requirements continue to apply.

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

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

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

- Nursing facilities
- Assisted living facilities
- Adult day care centers
- Home and Community Support Services Agencies (HCSSAs)
- Licensed adult Foster Care Providers

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

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

- A child/youth with a disability or child residing in or receiving services from one of the following Providers or their health plans:
  - Local Intellectual and Developmental Disability Authority (LIDDA)
  - Local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid-Managed Care Organization (MCO) 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.

Report to Community First Health Plans

- In addition to reporting to HHSC and DFPS, a care Provider must report the findings within (1) one business day to Community First.
- Providers should submit a copy of the ANE findings and the individual remediation within (1) one business day of receiving the findings from DFPS.

Failure to Report or False Reporting

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

7. INSURANCE

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

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

8. MARKETING

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

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

9. PROVIDER NETWORK REQUIREMENTS

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

10. NON-DISCRIMINATION BY PARTICIPATING PROVIDER

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

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

11. MEDICAL RECORDS DOCUMENTATION GUIDELINES

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

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

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) and the International Classification of Diseases, 9th Revision Clinical Modification (ICD-10 CM) systems be used to report professional services, including Physician services and diagnoses. Correct use of CPT and ICD-10 coding requires using the most specific code that matches the services provided and illnesses based on the code's description. Providers must pay special attention to the standard CPT descriptions for 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 themself.

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 timely documented if originally completed after thirty (30) days of the date of service.

Definitions

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

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

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

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

Medical Record Documentation

Community First requires all Providers to create and keep appropriate medical records in compliance with generally accepted medical records standards. All medical records must be kept for at least five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding Rural Health Clinics (RHC) must be kept for a period of six years from the date of service; and Hospital-based RHC must be kept for a period of 10 years from the date of service.

The Provider agrees to provide, at no cost to the MCO, records requested for the purpose of Healthcare Effectiveness Data and Information Set (HEDIS) audits or Special Investigation Unit audits. Upon receipt of the request, the 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 or submission to the OIG for failure to supply records.

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

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

Upon receipt of a record review request, a Provider must comply at no cost to the requesting agency, HHSC, Office of the Inspector General (OIG), or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions. The records must be provided within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and in less than 24 hours, the Provider must provide the records requested at the time of the request 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, or 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 contracts with Providers and subhealth plans. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the Provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.

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

- **Patient identification information**. Each page or electronic file in the record contains the patient's name and patient ID number.
- **Personal/biographical data**, including age, sex, address, employer, home and work telephone numbers, and marital status.
- **All entries are legible** to individuals other than the author, dated, and signed by the performing Provider.
- **Allergies.** Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies — NKA) is noted in an easily recognizable location.
- **Evaluation and Management codes** are supported by the documentation in the clinical record. Providers must follow the most current CMS documentation guidelines when selecting the level of service provided.

- **Immunizations.** For pediatric records there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Medically necessary **diagnostic lab and X-ray results** are included in the medical record and include an explicit plan of care for any abnormal findings.
- Required follow-up visits specify time of return by at least the week or month.
- **Unresolved problems** are noted in the record.
- Member is provided **basic teaching/instructions** regarding physical and behavioral health condition.
- **Smoking/Alcohol/Substance Use Disorder.** Notation concerning cigarettes and alcohol use and substance use 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 department) 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. Summaries should pertain to admissions that may have occurred prior to the Member being enrolled with the health plan and are pertinent to the Member's current medical condition.
- **Advance Directive.** For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- Providers are required to submit information for **the Health Passport.**
- **Evidence and results of medical, preventive, and behavioral health screening.**
- **All treatment provided** and results of such treatment.
- **The team members involved** in the multidisciplinary team of a Member needing specialty care.
- **Integration of clinical care** in both the physical and behavioral health records.
- **Screening for behavioral health conditions** (including those which may be affecting physical health care and vice versa) and referral to Behavioral Health Providers when problems are indicated.
- **Screening and referral by Behavioral Health Providers** to PCPs when appropriate.
- **Receipt of behavioral health referrals** from Physical Medicine Providers and the disposition/outcome of those referrals.
- At least quarterly (or more often if clinically indicated), **a summary of status/ progress from the Behavioral Health** Provider to the PCP.
- **A written release of information** which will permit specific information-sharing between Providers.
- **That behavioral health professionals are included** in primary and specialty care service teams described in the contract when a Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Release of Information

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

12. CREDENTIALING AND RECREDENTIALING

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

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

- Member survey results
- Complaints and Grievances
- Utilization data
- Compliance of Community First policies and procedures
- An office site review and evaluation
- A medical record audit

Advance Nurse Practitioner Requirements

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

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

Advance Nurse Practitioner Benefits and Limitations

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

- Are within the scope of practice for Advance Nurse Practitioners, as defined by state law
- Are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate states licensing authority
- Would be covered by the Texas Medical Assistance Program if provided by a licensed Physician (MD or DO)

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

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

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 HEDIS quality data, and to confirm the services billed to Community First. Record reviews are considered an essential method of identifying potential quality of care issues and opportunities for Practice Guideline development.

Community First adopted medical record standards that assist with evaluating patient care to ensure conformance with Quality-of-Care Standards. Providers must conform to the standards to remain a Network Provider. Providers will be evaluated at least every three years and will be notified of the scheduled audit by the Quality Management Department prior to the review. The audit routinely consists of three components:

- Documentation
- Continuity of Care
- Preventive Care

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

13. UPDATES TO CONTACT INFORMATION

Providers must inform both Community First and HHSC's administrative services health plan of any changes in the Provider's profile information, such as address, telephone number, or group affiliation. Medicaid-enrolled Providers providing Medicaid-only covered services and LTSS must also notify TMHP of any changes in organizational structure or demographic information.

14. MANDATORY CHALLENGE SURVEY

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

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

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

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

15. CONFIDENTIALITY

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

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

16. POTENTIALLY PREVENTABLE COMPLICATIONS (PPC) AND PROVIDER PREVENTABLE READMISSIONS (PPR)

Potentially preventable complications are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care Providers.

The PPC analysis is performed in accordance with TAC, §354.1446 Potentially Preventable Complications in the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC programs.

PPCs are classified into two separate categories:

1. Hospital-Acquired Conditions (HAC)
    a. As part of the payment determination, the Centers for Medicare and Medicaid Services (CMS) has designated fourteen (14) categories of hospital-acquired conditions (HAC), which are conditions not present on admission (POA).

    Category 1: Health Care-Acquired Conditions (For Any Inpatient Hospital Setting in Medicaid)

    - Foreign Object Retained After Surgery
    - Air Embolism
    - Blood Incompatibility
    - Stage III and IV Pressure Ulcers
    - Falls and Trauma, including Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, Electric Shock
    - Catheter-Associated Urinary Tract Infection (UTI)
    - Vascular Catheter-Associated Infection
    - Manifestations of Poor Glycemic Control, including Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
    - Surgical Site Infection Following:
        - Coronary Artery Bypass Graft (CABG) - Mediastinitis
        - Bariatric Surgery, including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
        - Orthopedic Procedures, including Spine, Neck, Shoulder, Elbow
    - Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions

Category 2: Other Provider-Preventable Conditions (For Any Health Care Setting)

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
- OPPCs identified in the state's plan and according to the requirements of the final regulation

Potentially preventable readmissions are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. Texas Medicaid uses a 15-day readmission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care Providers.

PPR Analysis

The PPR analysis is performed in accordance with TAC, §354.1445 Potentially Preventable Readmissions. (Texas Administrative Code Rules)

On an annual basis MCOs and hospitals receive access to their state fiscal year (SFY) PPR and PPC hospital level reports and underlying excel data files. These reports are compiled using claim data from managed care organization inpatient data. The MCO is responsible for configuring their payment systems to ensure these reductions are applied. Community First utilizes the Optum software which is pre-configured with these rate reductions.

B. QUALITY IMPROVEMENT PROGRAM

Community First's Quality Improvement Plan (QIP) is designed to communicate the overarching organizational work plan to achieve optimal care with emphasis on safety and service to health plan Members, and to facilitate a culture of continuous improvement. It includes essential information on the structure Community First will operationalize to manage, deploy, and review quality throughout the organization, including a detailed description of the organizational structure, staffing, and the committees required to support Community First quality initiatives and the scope of responsibilities.

The QIP is updated regularly to reflect what Community First is doing to improve quality and is developed as an outgrowth of the evaluation of the previous years' quality improvement activities, organizational priorities, and program requirements. It defines the lines of accountability between the quality improvement program and the Community First Board of Directors.

Committees meet regularly to report findings, recommendations, and resolutions/ corrective action plans through the Quality Infrastructure. Operational meetings are held on a routine basis to allow for timely communication throughout the organization.

Key areas responsible for the QIP include all areas of the organization, from the President/CEO to every department and committee at Community First.

1. DELEGATION OF QIP ACTIVITIES

Community First does not delegate any QIP management activities.

Providers who have been delegated activities, such as credentialing or utilization review, are required to have quality improvement programs in place which meet all the requirements of Community First and 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.

2. PRACTICE GUIDELINE DEVELOPMENT

Community First has established a process for evaluating patterns of care for specific conditions and procedures. Clinical Guidelines, including Pediatric and Adult Preventive Care guidelines and Disease Management guidelines, have been reviewed and approved by the Quality Improvement Committee.

The Quality Improvement Committee has also approved practice guidelines for both asthma and diabetes. These guidelines will be used to assess the quality of health care delivery for these disease entities. Other practice guidelines may be developed and approved by the Quality Improvement Committee. Compliance with the guidelines is evaluated during clinical and medical record reviews.

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 CHIP Members upon request.
- Maintaining the confidentiality of CHIP 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 Provider Relations Representative.

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

3. 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 CHIP Members in a behavioral health medical record audit.

4. OFFICE SITE VISIT/POTENTIAL QUALITY ISSUES (PQIs)

As part of our 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

Providers can refer to the Medical Record Review Tool and Preventive Services for Adults. 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.

Office Site Survey

Community First's QIC has adopted guidelines for office sites. Community First may conduct a site visit to the office of any Physician or Provider at any time for cause. Community First will conduct the site visit to evaluate any complaints or other

precipitating events, which may include an evaluation of any facilities or services related to the complaint and an evaluation of any/all of the following:

- Physical accessibility (Provider offices are required to be accessible to Members with disabilities);
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Appointment availability; and
- Equipment.

The survey will be conducted by Community First Account Management staff or designee or through a contracted vendor.

Once the survey is completed, it is scored. If the score is less than 80%, or if any elements in the "access for the disabled" section of the form are not met, the Provider office is required to submit a corrective action plan to Community First within 30 days.

Following submission of the corrective action plan, a second survey is scheduled within six months to evaluate compliance with office site guidelines.

If Community First receives another complaint about the same aspect of the performance for the office site within six months after completing the site visit, Community First will determine whether the practitioner's previous office site visit met the plan's standards and thresholds. If that is the case, Community First will follow up on the complaint and a subsequent visit is not required.

Survey Results

At the conclusion of an office site survey, the results will be reviewed with the Provider and/or a designated staff member. The Provider may make a copy of the survey for their records. If there are deficiencies, the Provider may be asked to submit a corrective action plan.

C. UTILIZATION MANAGEMENT

Community First's Utilization Management program determines whether proposed or rendered medical services and supplies are medically necessary and appropriate, are of a generally acceptable high quality and appropriate frequency, done in the appropriate setting, and covered in the CHIP Member's benefit plan. Program components include preauthorization, concurrent stay review, discharge planning, retrospective review, disease management, and case management.

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

NOTE: These determinations only affect payment for services by Community First. The decision to provide treatment is between the CHIP Member and the attending Physician.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. Community First does not specifically award

practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Utilization management decisions are made in accordance with currently accepted medical or health care practices, taking into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. Criteria are used for the review of medical necessity, as well as Provider peer-to-peer review. The medical director reviews all potential Adverse Benefit Determinations for medical necessity. At least annually, the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria. Utilization review decision making is based on appropriateness of care and service and the existence of coverage. Community First does not reward Providers or other individuals for issuing medically necessary denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

InterQual criteria are used to determine medical necessity. InterQual was developed by generalist and specialist Physicians representing a national panel from academic as well as community-based practices, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. Community First also utilizes 28 T.A.C. §3.8001 et seq. for substance use disorders.

Besides processing requests for authorizations, Utilization Management analyzes utilization patterns and provides an appeal process to address disputes in a timely manner.

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

"Prior Authorization Not Required" does not mean that service is covered. Please contact Member Services at **210-358-6060** should you have questions regarding covered services.

Successful operation of our Utilization Management program depends upon the Provider's cooperation by:

- Accepting and returning our phone calls concerning our CHIP Members.
- Providing Community First with complete medical documentation to support any preauthorization requests.
- Allowing us to review medical and billing records concerning care rendered to our CHIP Members to validate delivery of care against claims data.
- Participating with us in discharge planning, disease management, and case management.
- Participating with our Community First's committee proceedings when appropriate.

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

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

D. PROVIDER COMPLAINT AND APPEAL PROCESS

1. PROVIDER COMPLAINTS TO COMMUNITY FIRST

Community First has a process to address Provider complaints in a timely manner, which is consistent for all Network Providers. Community First and the Provider have an obligation under their mutual contract provisions to make a good faith effort to resolve any disputes arising under the agreement. In the event a dispute cannot be resolved through informal discussions, the Provider must submit a complaint to Community First which specifically sets forth the basis of the complaint along with a proposed resolution. Providers are able to file a complaint through a variety of mediums.

- Calling Provider Relations to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Community First employee.
- Completing the Provider Complaint Form on the Community First website at CommunityFirstMedicaid.com.
- Mailing a written complaint to:
  Community First Health Plans
  12238 Silicon Drive, Ste. 100
  San Antonio, TX 78249

Providers should retain the following documentation:

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

Upon receipt of a written Provider complaint, the Network Management Department will send a letter acknowledging receipt of the complaint within five (5) working days from the date of receipt. Following investigation of the complaint, 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. 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. Provider appeals must be submitted no later than thirty (30) days of the complaint response letter. 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 their right to submit the complaint to binding arbitration. Any binding arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association, unless the Provider and Community First mutually agree to some other binding arbitration procedure.

2. PROVIDER APPEALS TO COMMUNITY FIRST

If you wish to appeal a decision made by Community First that the health care services furnished or proposed to be furnished to a CHIP Member are not medically necessary, you or the Member may appeal orally, followed up with a written appeal.

- Members: Orally, by calling **210-358-6060** or **1-800-434-2347**
- Providers: Orally, by calling **210-358-6294** or **1-800-434-2347**
- Via the Community First secure Provider Portal by clicking the "Contact Us" link
- Via fax to Community First's Provider Relations Department at **210-358-6199**
  - Please include fax cover sheet along with Provider Complaint Form.

Providers should retain the following documentation:

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

Provider Appeals Process

A. Within (5) working days from receipt of the appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the appeal. This letter will include a reasonable list of documents that need to be submitted to Community First for the appeal.

B. When Community First receives an oral appeal, Community First will send the appealing party a one-page Appeal Form.

C. 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.

D. After Community First has sought review of the appeal, we will provide written notification to the Member, Member's representative, and the Member's Physician or Health Care Provider explaining the resolution of the appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than thirty (30) days after we receive the oral or written request for appeal. The notification will include:
   - A clear and concise statement of the specific medical or contractual reason for the resolution
   - The clinical basis for such decision
   - The specialty of any Physician or other Provider consultant

If the appeal is denied, the written notification will include notice of the appealing party's right to seek a Member Independent Review Organization (IRO) (see Member Complaints and Appeals section).

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

3. PROVIDER COMPLAINT PROCESS TO TDI

A Provider, who believes they did not receive full due process from Community First, has the right to file a complaint with the Texas Department of Insurance at any time.

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
Fax: **(512) 475-1771**
Web: https://www.tdi.texas.gov/
Email: ConsumerProtection@tdi.state.tx.us

4. PROVIDER APPEAL PROCESS TO HHSC (RELATED TO CLAIM RECOUPMENT)

A Provider, who believes they did not receive full due process from Community First, has the right to file an appeal with the Texas Department of Insurance at any time.

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
Fax: **(512) 475-1771**
Web: https://www.tdi.texas.gov/
Email: ConsumerProtection@tdi.state.tx.us

E. MEMBER COMPLAINT/APPEAL PROCESS

1. MEMBER COMPLAINTS TO COMMUNITY FIRST

CHIP Members may file a complaint with Community First at any time.

A complaint means an expression of dissatisfaction expressed by a complainant, orally or in writing, to Community First about any matter related to the 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 **210-358-640**3 or toll-free at **1-855-607-7827**.

Members may also send written complaints to:

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

Members may contact Community First Member Services to request assistance in filing a complaint. Community First designates Member Advocates to support and assist Members who want to file a complaint and monitor the complaint through Community First's complaint process until the issue is resolved. Community First will mail a letter to the complainant within five (5) days to inform them that we have received their complaint. Following investigation of the complaint, we will send a letter to communicate Community First's resolution of the complaint within thirty (30) calendar days from the receipt of the complaint. If the response is not satisfactory, a complaint appeal may be filled.

If the Member is not satisfied with the outcome of the complaint, the Member may file a complaint with the Texas Department of Insurance (TDI).

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
Fax: **(512) 475-1771**
Web: https://www.tdi.texas.gov/
Email: ConsumerProtection@tdi.state.tx.us

2. 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 then 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

- 30 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 CHIP 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 acknowledgment 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.

3. MEMBER EXPEDITED APPEAL

Community First CHIP/CHIP Perinatal Members may request an expedited appeal if the CHIP Member is not satisfied with the denial of a covered benefit.

Community First CHIP Members may request an expedited appeal orally or in writing when Community First is required to make a decision quickly based on the Member's health status and taking the time for a standard appeal could jeopardize the Member's health such as a denial of emergency care, a life-threatening condition, or an inpatient hospitalization.

Community First Member Services can assist the CHIP Member in filing an expedited appeal.

The timeframe in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed one (1) working day following the date that the appeal is made to Community First.

The timeframe may be extended up to 14 calendar days if the Member requests an extension, or if Community First shows that there is a need for additional information and how the delay is in the Member's interest.

Community First will notify the Member if a request for an expedited appeal is denied. The request will be moved to the regular appeal process and the Member will be notified of the change by mail within two (2) calendar days.

4. MEMBER INDEPENDENT REVIEW ORGANIZATION (IRO)

What is an IRO?

An IRO is an Independent Review Organization that is not part of Community First. The IRO reviews unresolved appeals, as coordinated by MAXIMUS Federal Services State Appeals.

CHIP Members may submit a request for an IRO to Community First's Population Health Management Resolution Unit and the Resolution Unit will forward the request to MAXIMUS Federal Services State Appeals for assignment.

Members can give MAXIMUS additional information for your external review by sending to:

MAXIMUS Federal Services State Appeals
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: **1-888-866-6190**

Members can also visit the HHS-Administered Federal External Review Process website to request a review online.

What are the timeframes for requesting, reviewing, and resolving an IRO?

The IRO must make its determination by the 15th day after the IRO receives the information necessary to make a determination, or by the 20th day after the IRO receives the request.

5. APPEALING AN ADVERSE DETERMINATION

CHIP Members who receive a denial of services are notified by mail with an Appeal Form enclosed. Members can ask for an appeal of the adverse determination by mail or by phoning a Member Services Representative who can assist them. The Member must request an appeal within 60 days from the date of notification of the denial, reduction, or suspension of previously authorized services, or by the effective date of the action. Community First will send the Member a letter within five (5) calendar days to acknowledge receipt of the appeal and will mail the Member the health plan's decision within 30 calendar days.

Expedited Appeals

Members can request an expedited appeal for emergencies or hospital admissions, to continue current prescriptions and intravenous medications, or for denial of step therapy medication protocol exception. An expedited appeal requires Community First to make a decision quickly based on the condition of the Member's health, and when taking the time for a standard appeal could jeopardize the Member's life or health.

Members may ask for an expedited appeal by phone, in person, or in writing. Members also have the right to ask for an extension of up to 14 days if you would like to provide additional information to support your expedited appeal. A Community First Member Services Representative can help request an expedited appeal. Members should call Member Services at **1-800-434-2347** for assistance.

If Community First denies the request for an expedited appeal, the health plan will notify the Member within two (2) days that the appeal has been moved to the regular appeals process.

If Community First has all needed information, the health plan will have an answer within one (1) to three (3) days after the appeal is received.

The Member may ask for an External Review if not satisfied with Community First's decision on the appeal. Also, if Community First does not answer the regular or expedited appeal within the timelines given, the Member may request an External Review without waiting for the answer to the appeal by calling or writing MAXIMUS Federal Services at the following address:

HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

1-888-866-6205
Fax: **1-888-866-6190**

An External Review must be requested within four (4) months from the receipt of the Community First appeal decision letter. Community First will provide all the documents and information related to the denial to the External Reviewer. The External Reviewer will mail the Member and Community First the decision within 45 days after the date the examiner receives the request for External Review.

For life-threatening conditions, urgent care situations, and for current prescriptions and intravenous medications, the Member can call MAXIMUS to request an expedited External Review before or after exhausting the Community First appeal process. The reviewer will send a decision as soon as possible, but no later than three (3) days after the examiner receives the request for an expedited External Review.

F. ENCOUNTER DATA, BILLING, AND CLAIMS ADMINISTRATION

1. WHERE TO SEND CLAIMS/ENCOUNTER DATA

Paper Claims

Submit paper claims to the following address:

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

Community First requests that if you are submitting paper claims, the following steps be followed to expedite payment:

- Use 10 x 13-inch envelopes; send multiple claims in one envelope
- Do not staple, paper clip, or fold claim Forms or attachments
- Do not use red ink
- Whenever possible, generate your claims on a computer or typewriter (handwritten claims are difficult to read and scan)

Electronic Claims

Submit electronic claims via:

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

2. CLAIM FORM

Physicians, other Health Care Providers, and FQHCs must file paper claims using a CMS-1500 Claim Form and Instruction Table.

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.

NOTE: Only claims including all required information will be considered clean claims. Newborn claims should be submitted with all of the required elements above. However, if a CHIP number for the newborn is unavailable, use the mother's CHIP Member ID number with the correct date of birth for the newborn.

3. EMERGENCY SERVICES CLAIMS

Community First's policies and procedures, covered services, claims adjudication methodology, and reimbursement levels for emergency services comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. 438.114, whether the Provider is a participating Provider or out of network. Community First's policies and procedures are consistent with a prudent layperson's definition of an emergency medical condition and the claims adjudication processes required under the contract with HHSC and C.F.R. 438.114.

Community First will pay for the professional, facility, and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a Member presenting as an emergency medical condition or an emergency behavioral health condition to a hospital emergency department, 24 hours a day, 7 days a week, rendered by either a participating Provider or an Out-of-Network Provider.

Community First does not require prior authorization as a condition for payment for an emergency medical condition, an emergency behavioral health condition, or labor and delivery. Nor does Community First hold the Member liable for the payment of subsequent screening and treatment to diagnose the specific condition or stabilize the Member who had an emergency medical condition.

PCPs should become actively involved in educating CHIP Members regarding the appropriate use of the emergency department and other emergency services. PCPs should notify Community First of any Member who may need further education by calling Member Services.

If a Member has an emergent condition, the emergency department 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 department staff must notify Community First to arrange for medically necessary hospital admission or follow-up care with the Member's PCP.

4. PHARMACY CLAIMS

- Clean claims submitted electronically will be adjudicated within 18 days of receipt. Clean claims submitted non-electronically will be adjudicated within 21 days of receipt.
- Claim submission requirement (within 95 days)
- Approved claim Forms

5. COST SHARING SCHEDULE

There are two types of cost share obligations enrollment fees and copayments. Most CHIP-eligible households are subject to cost share obligations.

Cost Share Obligation Exceptions

- Households with a gross income at or below 151% of the Federal Poverty Income Limit (FPIL) are not subject to an enrollment fee;
- American Indians and Alaska Natives are exempt from all cost sharing. American Indian or Alaska Native status is self-declared on the application. If one child within the household is an American Indian or Alaska Native, the entire household application has American Indian or Alaska Native status; and
- Unaccompanied refugee minors are exempt from all cost sharing.

Cost sharing is processed by the Enrollment Broker.

CHIP Perinatal recipients are not subject to cost share obligations. Perinatal recipients do not pay enrollment fees or copayments.

Additionally, for **CHIP Members**, there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

CHIP Cost-Sharing	
	Effective January 1, 2014
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% of FPL*	**Charge**
Office Visit (non-preventative) No co-pays are applied for mental health/substance use disorder office visits.	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Copay, Inpatient (per admission) No co-pays are applied for mental health/substance use disorder residential treatment services.	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative) No co-pays are applied for mental health/substance use disorder office visits.	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Copay, Inpatient (per admission) No co-pays are applied for mental health/substance use disorder residential treatment services.	$75
Cost-sharing Cap	5% (of family's income)
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventative) No co-pays are applied for mental health/substance use disorder office visits.	$25
Non-Emergency ER	$75
Generic Drug	$10

CHIP Cost-Sharing	
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Copay, Inpatient (per admission) No co-pays are applied for mental health/substance use disorder residential treatment services.	$125
Cost-sharing Cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

6. MEMBER BILLING

By entering into an agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services rendered to Members. **By contract you cannot bill Members for the difference between your normal charge and the payment rate that you negotiated with Community First for rendering covered services.**

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

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

- Failure to submit a claim, including claims not received by Community First
- Failure to submit a claim to Community First for initial processing within the 95-day filing deadline
- Failure to submit a corrected claim within the 120-day filing re-submission period
- Failure to appeal a claim within the 120-day appeal period

Payment for Services

The Provider is prohibited from billing or collecting any amount from a Medicaid Member for "health care services" rendered pursuant to the Provider contract. Federal and state laws impose severe penalties for any Provider who attempts to bill or collect any payment from a Medicaid recipient for a covered service.

The Provider understands and agrees that HHSC is not liable or responsible for payment of covered services rendered pursuant to the Provider contract.

7. TIME LIMIT FOR SUBMISSION OF CLAIMS

Providers are required to submit claims to Community First ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Provider Relations at **210-358-6030**.

Proof of Timely Filing

Community First accepts the following as proof of timely filing:

- Returned receipt (Certified Mail)
- Electronic confirmation from Community First vendor
- Receipt of claim log signed by Community First employee

8. CLAIMS SUBMISSION

Community First will provide the Provider at least 90 days' notice prior to implementing a change in the above-referenced claims guidelines unless the change is required by statute or regulation in a shorter timeframe.

Providers are required to submit claims to Community First ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Community First Health Plan's Provider Services at **210-358-6030**.

1. Community First will adjudicate all clean claims within thirty (30) days from the date Community First receives the clean claim(s).
2. Community First will notify Providers within thirty (30) days from the date we receive the claim(s) if we will deny or pend the claim(s) and the reason(s) for the denial.
3. Community First will pay Providers interest on any clean claim(s) we do not adjudicate within thirty (30) days from the date Community First receives the clean claim(s). Community First will pay the interest at a rate of 1.5 percent per month (18 percent annually) for each month we do not adjudicate within 30 days.

Unless otherwise specified in the Professional Provider Agreement, the payment methodology applicable to the Provider is:

- One hundred percent (100%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network for Community First, the applicable payment methodology is defined by HHSC and is equal to ninety-five percent (95%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.
- Providers who are considered out-of-network and out of the Bexar Service delivery area, the applicable payment methodology is defined by HHSC and is equal to one hundred percent (100%) of the current State of Texas CHIP Fee Schedule, as may be amended from time to time.

The Texas CHIP Fee Schedule is available at TMHP.com and by calling **1-800-925-9126**.

Program Violations

Violations arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G. *Network*.

Supervised Providers

Providers must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised Providers.

9. EOP, DUPLICATE CHECKS, AND CANCELED CHECK REQUESTS

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

NOTE: Check printing errors that result in duplicated checks should be reported to Community First as soon as identified. Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed. Any bank fees that Provider accrues after Provider deposits or cashes a duplicate check will not be reimbursed by Community First.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of $15.00 per EOP and $20.00 per check. The request for a copy of the EOP or check must be submitted in writing along with the appropriate fee. The request must include the date of the EOP, the name of Provider, and date of the check. Send the request to the following address:

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

10. SPECIAL BILLING

The following special billing guidelines are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. **Always** use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.
- The name of your claim should be the same name as it appears on the Your Texas Benefits CHIP card.
- Make sure the sex of the Member listed on the claim is accurate.
- Value-added services do not require billing.

11. BILLING AND CLAIMS ADMINISTRATION

Coordination of Benefits

A third party may cover some CHIP Members (e.g., auto liability, disability, or workers' compensation). In situations where a CHIP Member has other insurance, the other insurance carrier will be the primary payor. Providers must bill the third-party insurance

first and then attach a copy of the Explanation of Benefits (EOB) statement received from the third-party insurance to the claim when filing with Community First for reimbursement. Providers must file claims to Community First within ninety-five (95) days of the third-party insurance EOB. As a payor for Medicaid services, Community First will act as the payor of last resort. Community First will deny payment for claims that do not include proof of prior filing with the CHIP Member's third-party insurance. If a CHIP Member indicates they do not have a third-party insurance, instruct the Member to contact Community First's Member Services Department for assistance.

Third Party Recovery

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

Explanation of Payment (EOP)

You will receive an Explanation of Payment (EOP) Sample. 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 or letter with a copy of the EOP to the claims address listed at the beginning of this section.

Appeals of "For Cause" HMO Agreement Termination

Community First must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider, including an STP. At least 30 days before the effective date of the proposed termination of the Provider's contract, Community First must provide a written explanation to the Provider of the reasons for termination. Community First may immediately terminate a Provider contract if the Provider presents imminent harm to patient health, actions against a license or practice, fraud, or malfeasance.

Within 60 days of the termination notice date, a Provider may request a review of Community First's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license, fraud, or malfeasance. The advisory review panel must be composed of Physicians and Providers, as those terms are defined in §843.306 Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Community First. The decision of the advisory review panel must be considered by Community First but is not binding on Community First. Community

First must provide to the affected Provider, on request, a copy of the recommendation of the advisory review panel and the Community First's determination.

According to your agreement with Community First, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If we give you a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure. This procedure is available only if we are terminating your agreement for the reasons stated above.

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

Notice of Proposed Action

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

Upon termination of your agreement, you may request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to Community First's Medical Director. You should include any explanation or other information with your request for reinstatement. The Community First's Medical Director will appoint a committee to review your request, and any information or explanation provided within thirty (30) days of receipt. The committee will recommend an initial decision to the Board of Directors either to terminate your Membership and reaffirm your agreement, reaffirm with sanctions, or to revoke.

Decision

Within ten (10) days of receiving the committee's recommendations Community First will, by special notice in registered or certified mail, inform you of Community First's decision on your request for reinstatement. This decision will be final.

12. CLAIMS QUESTIONS/APPEALS

Providers have the right to appeal the denial of a claim by Community First. The Provider has **90 days** from the date of the most recent Community First's EOP to appeal the denial. Community First will not accept any appeal submitted after the appeal deadline or appeals older than two (2) years. Providers may submit a Claim Appeal Submission Form, via mail to the following address:

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

Providers can also submit the appeal request electronically using Community First's secure Provider Portal.

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

13. ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE

Community First partners with PaySpan for EFT and ERA.

G. SPECIAL ACCESS REQUIREMENTS

1. INTERPRETER/TRANSLATION SERVICES

Community First Member Services includes Representatives who can speak to Members in English or Spanish, or we can get an interpreter who speaks their languages.

Community First has interpretive services available for its CHIP Members to ensure effective communication regarding treatment, medical history, or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide Community First CHIP Members access to professionals trained to help with technical, medical, or treatment information when a family Member or friend interpreter is inappropriate. To arrange for a sign interpreter or language interpreter for a Community First CHIP Member, please contact Community First's Member Services Department at **210-358-6030**.

2. COMMUNITY FIRST AND PROVIDER COORDINATION

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

Community First will operate a toll-free telephone line (**1-800-434-2347**) for Providers from 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday. The Provider Hotline will be staffed with personnel who are knowledgeable about Covered Services for CHIP, about non-capitated services, and general health plan operations to assist the Provider.

3. READING/GRADE LEVEL CONSIDERATION

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

4. CULTURAL SENSITIVITY

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

CHIP PROVIDER MANUAL

COMMUNITY FIRST HEALTH PLANS

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