HMO D-SNP

PROVIDER ORIENTATION & TRAINING

CommunityHealthChoice.org
Provider.CommunityHealthChoice.org/Medicare
713.295.5007
Toll free 1.833.276.8306

The purpose of this *Provider Orientation & Training* is to provide a general overview of the information you and your staff will find in the Provider Manual.

About Community Health Choice

- Non-profit Managed Care Organization (MCO) licensed by the Texas Department of Insurance (TDI)
- Serves more than 400,000 Members with the following programs:
  - STAR for low-income children and pregnant women
  - CHIP for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR
  - Marketplace plans for individuals, including subsidized plans for low-income families
  - Medicare Dual Special Needs Plan (HMO D-SNP), a CMS-authorized program for people eligible for both Medicare and Medicaid
  - Administrator for collaborative safety net projects such as the Delivery System Reform Incentive Payment (DSRIP) and Network Access Improvement Program (NAIP), among others
- *Health Plan with Health Insurance Marketplace* accreditation by URAC.
- An affiliate of the Harris Health System, Community Health Choice (Community) is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.

Community's Vision, Mission, Values

Our Vision

- Community's vision is **a healthy life for every Texan**.

Our Mission

- Our mission is to improve the health and well-being of underserved Texans by opening doors to healthcare and health-related social services.

Our Values

- The team members of Community are **trustworthy, caring** individuals who work **collaboratively** with our members, providers and community partners. We are **courageous**, **creative** and **responsive** as we serve members and the community.

Program Overview & Objectives

Community participates in the Medicare D-SNP through a contract with the Centers for Medicare and Medicaid Services (CMS).

Under the D-SNP Program, eligible Members choose an MCO and a Primary Care Provider (PCP) to coordinate all services. The objectives of the Community Health Choice (HMO D-SNP) Program are as follow:

- Improve access to care for Community Health Choice (HMO D-SNP) Program Members
- Increase quality and continuity of care for targeted Medicaid Members
- Decrease inappropriate utilization of the healthcare delivery system
- Achieve cost-effectiveness and efficiency for the state
- Promote Provider and Member satisfaction

Community's Service Area: HMO D-SNP

The service area includes 20 counties.

Contacts at Community

Provider Services	Monday – Friday, 8:00 a.m. – 5:00 p.m. **Phone** 713.295.5007 or toll-free 1.833.276.8306 **Website** https://provider.communityhealthchoice.org/medicare **Email** ProviderWebInquiries@CommunityHealthChoice.org
Physical Health	**Fax Numbers** **Prior Authorizations:** 713.295.7059 **Notification of Admissions:** 713.295.2284 **Clinical Submission:** 713.295.7030 **Complex Care & Discharge Planning:** 713.295.7030
Behavioral Health	**Inpatient Prior Authorizations Fax:** 713.576.0932 **Outpatient Prior Authorizations Fax:** 713.576.0931

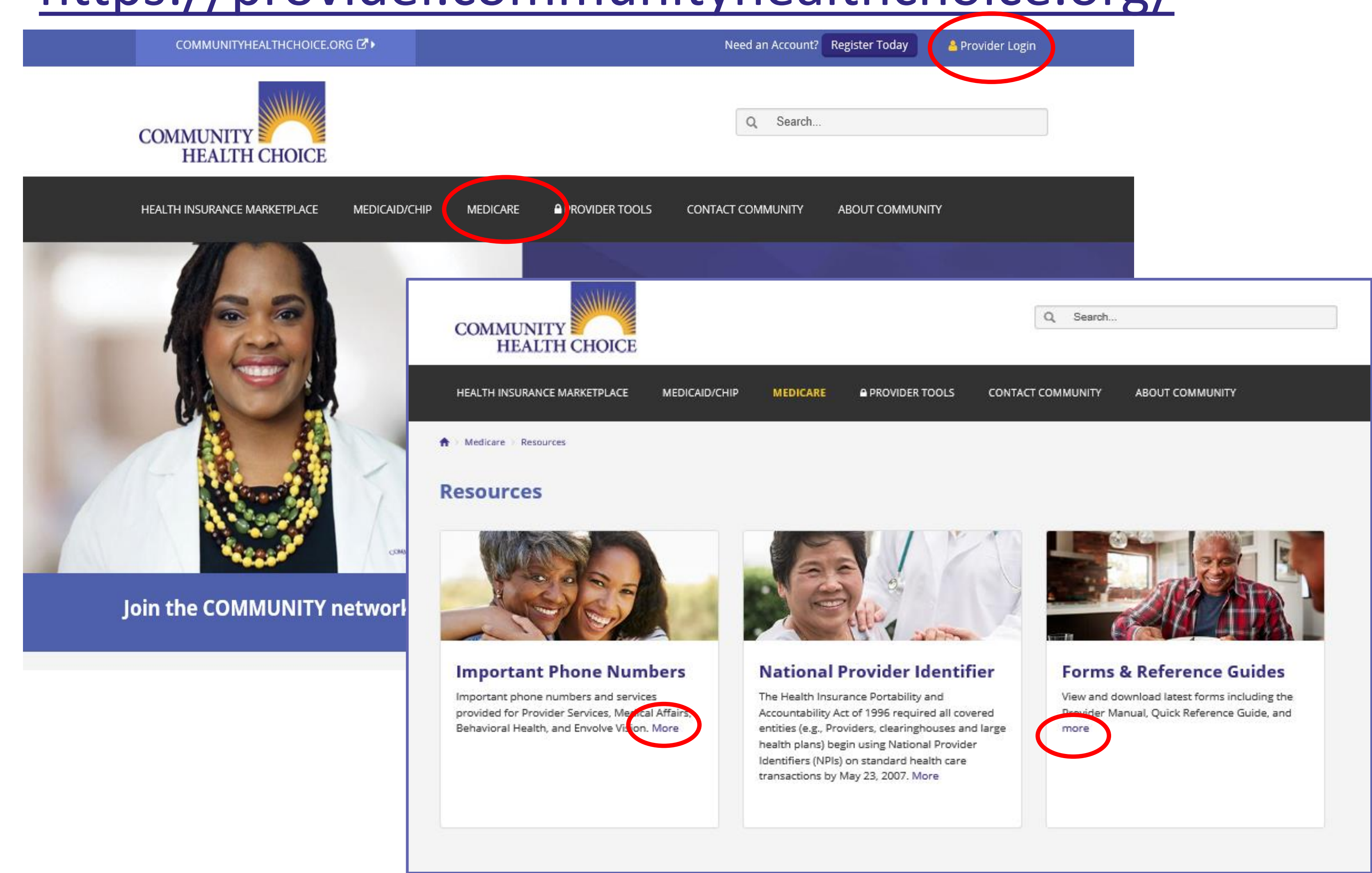
Contacts at Community

Mailed Claims	Community Health Choice Attn: Claims P.O. Box 301404 Houston, TX 77230
Refund Lockbox	Community Health Choice P.O. Box 4818 Houston, TX 77210-4818
Electronic Claims	Payer ID: **48145** • Change HealthCare Solutions, Inc. (formerly Emdeon/Relay Health): 1.877.469.3263 • Availity: 1.800.282.4548 • Gateway/TriZetto Provider Solutions: 1.800.969.3666
Adverse Determination and Appeals (Physical)	Community Health Choice Attn: Medical Appeals 2636 South Loop West, Suite 125 Houston, TX 77054 Fax: 713.295.7033 All appeals must be in writing and accompanied by medical records.
Adverse Determination and Appeals (Behavioral)	Community Health Choice Attn: Behavioral Health Appeals P.O. Box 1411 Houston, TX 77230 Fax: 713.576.0934 (Standard Appeal Requests) Fax: 713.576.0935 (Expedited Appeal Requests) All appeals must be in writing and accompanied by medical records.
Behavioral Health – Crist Line (Members)	Toll Free: 1.877.343.3108

Provider Manual, Quick Reference Guide, Preauthorization List, and other information available in the Provider Portal.

Provider Portal

https://provider.communityhealthchoice.org/



Member Eligibility

To join Community Health Choice (HMO D-SNP), the Member must be:

- Entitled to Medicare Part A
- Enrolled in Medicare Part B
- Live in our service area
- Texas Medicaid eligible categories: QMB or QMB Plus.

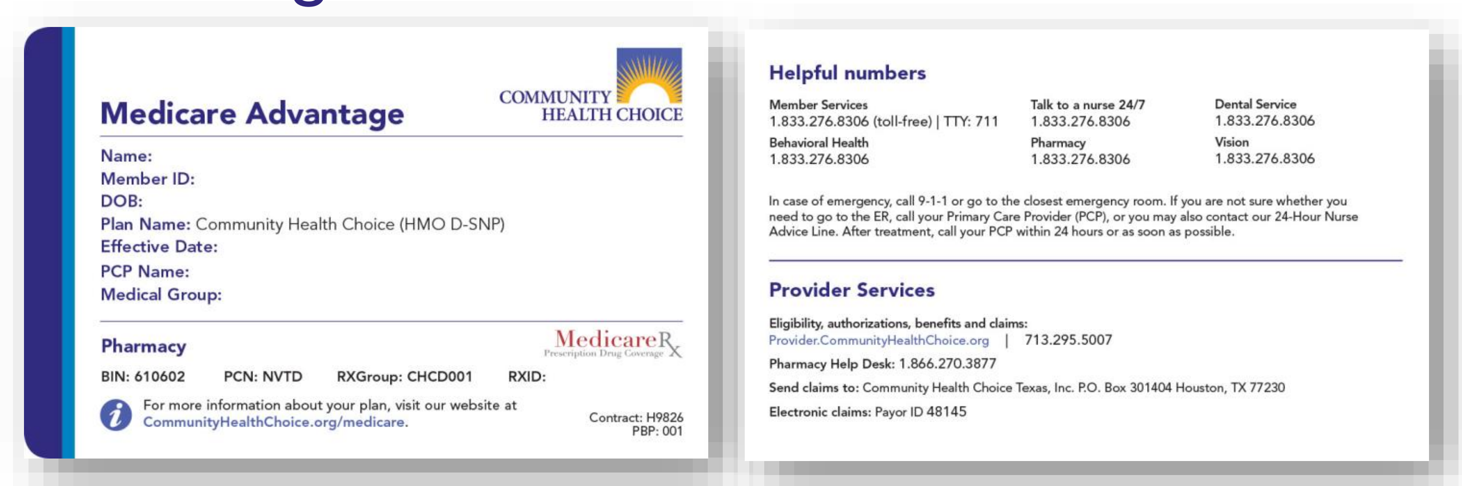
As a dual eligible, beneficiary services are paid first by Medicare and then by Medicaid. Medicaid coverage varies depending on income, resources, and other factors. Benefits may include full Medicaid benefits and/or payment of some or all of the Member's Medicare cost-share (premiums, deductibles, coinsurance, or copays).

Below is a list of dual eligibility coverage categories for beneficiaries who may enroll in the Community Health Choice (HMO D-SNP) Plan:

Qualified Medicare Beneficiary Program (QMB)	QMB Plus
Medicaid pays premiums, deductibles, coinsurance, and copayments for Medicare services furnished by Medicare Providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them).	For full Medicaid coverage, Medicaid pays Medicare premiums, deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMB Plus Members are not liable for them).

Verifying Member Eligibility

- To verify eligibility:
  - Obtain via Provider Portal
  - Call Provider Services
- All Members receive an ID Card from Community.
- All Members must select a PCP or Community will assign one.



Covered Services

	Community Health Choice (HMO D-SNP)
Covered Services	Inpatient and outpatient hospital Urgent Care Emergency Physician services Lab X-ray Behavioral health services Pharmacy
Supplemental Benefits/Value-Added Services	Dental Vision Transportation Meal Benefit Over the Counter Allowance (OTC)

For additional information, please refer to the Summary of Benefits or Explanation Coverage at

- https://www.communityhealthchoice.org/en-us/medicare/plan-material-and-forms/#2020-summary-of-benefits
- or call Provider Services at 713-295-5007

Benefits Administration & Beneficiary Protections

- Medicare Advantage organizations (MAOs) must ensure their organization and its contracted hospitals and critical access hospitals (CAHs) implement the provisions of the Notice of Observation Treatment and Implication for Care Eligibility Act or the NOTICE Act. Under the NOTICE Act, hospitals and critical access hospitals (CAHs) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as an outpatient for more than 24 hours.

- All MAOs and other Part C Providers and suppliers, including pharmacies, must refrain from collecting Medicare cost sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) program, a dual eligible program that exempts individuals from Medicare cost-sharing liability.

- Providers will be informed if Member cost-sharing liability is zero. Community Health Choice (HMO D-SNP) will provide real-time information and indicators through automated eligibility-verification systems, online provider portals and phone query mechanisms, and will clearly indicate Members owe $0 directly on the Explanation of Payment statements.

- Providers cannot discriminate against Members based on their payment status, e.g., specifically, Providers may not refuse to serve Members because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Credentialing/Recredentialing

- Providers must have a Medicare number.
- Providers cannot be "excluded": Preclusion List, Office of Inspector General (OIG), or System for Award Management (SAM)
- Aperture (Credentials Verification Organization) notifies providers of recredentialing requirements 180 days prior to the recredentialing deadline.
- Providers should submit a new, updated, fully completed, correct and attested Standardized Credentialing Application or updated CAQH application along with required attachments at least 120 days ***before*** the required date to re-credential.
- If for "any" reason due to any parties' action or inaction a provider is not recredentialed on the day 3 years from previously being credentialed, the provider will be placed in non–par status, removed from the directory, and terminated within 30 days for "failure to recredential".
- Facilities use *Availity* for online submission.

Behavioral Health Services: PCP Coordination

PCPs:

- Must screen, evaluate, refer and/or treat any behavioral health problems and disorders.
- May provide behavioral health services within the scope of practice
- Must maintain Member’s confidentiality of Behavioral Health information
  - The provider is required to obtain consent for disclosure of information from the Member in order to permit the exchange of clinical information between the Behavioral Health provider and the Member’s Primary Care Physician.
  - If the Member refuses to sign a release of information, documentation will need to indicate that the Member refused to sign. In addition, the provider will document the reasons for declination in the medical record.

Behavioral Health Services: PCP Coordination

Community developed a comprehensive PCP Toolkit for PCPs, to assist in identifying and treating behavioral health issues. It includes information on the most common behavioral health issues, including guidelines for diagnosis and treatment, fact sheets for Members, and assessment tools. You may access the PCP Toolkit online via our Provider Portal.

Conditions included in the toolkit:

- ADHD in Children and Adults
- Alcohol and substance abuse/addiction
- Anxiety
- Autism
- Bipolar Disorder
- Eating disorders
- Major Depression
- Opiates
- PTSD
- Schizophrenia

For additional information, visit the SAMHSA website to obtain a copy of:

“Core Competencies for Integrated Behavioral Health and Primary Care”

https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf

Provider Responsibilities: All Providers

- Verify Member eligibility
- Provide at least 30 days' written notice to Community and any other entity as applicable (i.e., CMS, State Board of Medical Examiners, NPPES, IPA, etc.) of any changes to demographic or billing information
  - W-9 required if updating billing information
- Provide at least 90 days' written notification of termination from Community, retirement or move outside of service area

Provider Responsibilities: All Providers
Advance Directives

- A Member has the right to make decisions about their treatment in the event that the Member is not able to make those decisions at the time they are needed.
  - "Directive to Physician" or "Medical Power of Attorney"

- A Member has the right to declare preferences or provide directions for mental health treatment including electroconvulsive or other convulsive treatment and treatment of mental illness with psycho-active medication, as defined by the Health and Safety Code, as well as emergency mental health treatment.
  - "Declaration for Mental Health Treatment"

Provider Responsibilities: All Providers Fraud, Waste, and Abuse (FWA)

- A person who intentionally misrepresents material facts by withholding correct information or providing false information necessary to administer Covered Services, can be held liable under fraud, waste, and abuse.
- Health insurance fraud may be a criminal offense that can be prosecuted.
- Any person(s) who willingly and knowingly engages in an activity intended to defraud Community by filing a claim or form that contains a false or deceptive statement may be committing insurance fraud.
- If you suspect a Member (a person who receives benefits) or a Provider (e.g., doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.
  - Call the Compliance Hotline at 1-877-888-0002
  - CMS at www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html
  - Write to us:

Community Health Choice
Attn: Special Investigations Unit
2636 South Loop West, Ste. 125
Houston, TX 77054

Appointment Accessibility Standards

Service	Appointment Availability
Emergent	Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities
Urgent	Must be provided within 24 hours, including urgent specialty care and behavioral health services
Primary Routine Care	Must be provided within 14 days, including behavioral health
Specialty Routine Care	Must be provided within 21 days
Routine Care Dental	Within eight weeks
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days
Preventive Care Physical/Wellness Exams	• Newborns (less than 6 months of age): Within 14 days • Children (6 months to 20 years): Within 2 months • Adults (21 years and older): Within 90 days • New Members: Within 90 days of enrollment *Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. *CHIP Members should receive preventive care in accordance with AAP guidelines
Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission	• Within 7 days from the date of discharge • Within 30 days from the date of discharge

After-Hours Coverage

Acceptable
1. The office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member 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 telephone. Another recording is not acceptable.
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical Provider who can return the call within 30 minutes.

Unacceptable
1. The office telephone is only answered during office hours.
2. The office telephone is answered after-hours by a recording that tells Members to leave a message.
3. The office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed.
4. Returning after-hours calls outside of 30 minutes

Referrals

- Providers are able to refer Members to Community's website or the current Community Health Choice (HMO D-SNP) Provider Directory.
- Members may go to any in-network Provider.
- Members may self-refer to any in-network behavioral health Provider.
- Members can also call Community regarding how and where to obtain behavioral health services. No prior approval from the PCP is required.
- Providers may refer Members suspected of having a developmental delay or a developmental disability, seriously emotionally disturbed (SED), mental illness or chemical dependency by:
  - Calling Provider Services or
  - Faxing referral information to our dedicated behavioral health fax lines

Cultural Sensitivity

Cultural sensitivity refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Community Health Choice's interpretive services will help you provide care in a culturally competent manner.

Members requiring behavioral healthcare services preferably should be referred to treatment Providers who speak the Member's language and have an understanding of related cultural issues.

In the event that a Member requires a behavioral health Provider, speaks another language or has specific expertise with a specific culture, they may contact Member Services at 713.295.5007 or toll-free at 1.833.276.8606 to receive appropriate referrals.

Additional information available via the Provider Portal at: https://provider.communityhealthchoice.org/media/1857/cultural-competency-training-for-providers.pdf

Authorization of Services

- Prior authorization (sometimes referred to as pre-certification or pre-notification) determines whether non-emergent medical treatment is medically necessary, is compatible with the diagnosis, if the member has benefits, and if the requested services are to be provided in the appropriate setting.
- Prior authorization is not a guarantee of payment.
- The list of services requiring prior authorization is on the Prior Authorization Guide located on the Provider Portal, at https://providerportal.communityhealthchoice.org/Providers/Secure/auth_notif.aspx.
- A Provider may request authorization for out-of-network services which cannot be provided within the Community network.

Authorization of Services

- The preferred method for authorization requests is through the Provider Portal. Faxed and phoned in submissions may result in longer wait times for approval.
- We accept Community Health Choice's Preferred Prior Authorization Form as well as the Texas Standard Prior Authorization Form.
- Please submit authorization requests for Behavioral Health services separate from Medical/Acute care services.
- All observation and inpatient admissions require notification of admission within 24 hours or the next business day of admission for review of medical necessity.
- Admission notification is the responsibility of the facility and not accepted from the physician.
- Supporting clinical documentation should be submitted within 72 hrs.
- Lack of notification will result in administrative denial.

Automated Prior Authorization Process

TriZetto® Touchless Authorization Processing™ (TTAP) is a cloud-based healthcare IT solution for payers and providers. TTAP automates prior authorization and referral requests using a 278/275 based authorization engine.

- Soon, Community will make available TTAP as a solution that streamlines and automates the prior authorization process for Providers in our networks.
- In submitting prior authorizations to this automated, real-time solution, you will realize multiple benefits immediately, including:
  - Almost immediate, fully automated authorization responses
  - Simplified and expedited authorization transactions
  - Automated determination of authorization requirements
- There is no additional cost to you for using this solution.
- Your Provider Engagement Representative will contact you to schedule training for your practice.

Discharge Planning

Discharge planning should be initiated in a timely manner for every admission.

Early discharge planning is consistently shown to:

- Ensure safe discharge from a facility
- Avoid delays
- Coordinate home care needs
- Avert potentially preventable future readmissions

Discharge planning should include:

- Identification of discharge needs early in the hospital admission
- Coordination of discharge plans with multi-disciplinary team,
- Collaboration w/ the PCP to obtain important clinical information
- Assistance arranging and initiating post-discharge services.

Discharge Notification

Community's Utilization Management department requests notification within one (1) business day from date of discharge:

- Discharge date, discharge summary and discharge plan

- Advance notification will allow Community to provide accurate authorization for services rendered, and assist with coordination of potential discharge planning needs.

- All Providers are asked to provide copies of applicable records to Community as required to support authorization.

Continuity of Care

Continuity of Care – Medicare Members

- Members enrolled in a Community Medicare plan may continue services with their pre-enrollment Providers and access existing service authorizations at the time of enrollment for up to 90 days.
- Community evaluates and ensures continuity of care when a Member's PCP or specialist terminates from the plan. When possible, Community authorizes continued care with the Provider for the completion of treatment or until the Member can be safely transitioned to a contracted Provider. Such authorization may not be possible if the Provider has died, retired, lost medical license, received Medicare or Medicaid sanctions or has moved outside the service area.

Member Moves Out of Service Area

- Community requests that the Member tell us in writing if they move or change their address or phone number, even if these changes are temporary. If a Member moves out of the service area, they may no longer be eligible.
- Members can also notify Community's Member Services at 713.295.5007.

Pre-Existing Conditions

- Community does not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Community Health Choice Member.

Care Transitions

- HMO D-SNP Members are supported during care transitions from one care setting to another. Care settings refer to the home, home health care, acute care, skilled nursing facility, and other facility settings.

- Community evaluates Members for risk of transition and monitors home-based and facility services to prepare for planned transitions.

- Providers are required to notify Community of an acute or rehabilitation hospitalization, or SNF admission promptly. All transitions are tracked in the Community Health Choice care management system.

- Community provides Members with a single point of contact throughout the transition, who will ensure that Members are informed of transition plans and options and are connected to appropriate Providers based on their care needs and preferences. The single point of contact also coordinates with facility personnel to ensure that everyone has the information they need and that the records are appropriately updated, including the Member's HMO D-SNP Individualized Care Plan (ICP).

- Community's Behavioral Health Aftercare Program is designed to promote a smooth transition to post-hospitalization behavioral health care and improve the continuity of care for Members after a behavioral health hospitalization.

- A Service Coordinator, who is an RN or licensed behavioral health clinician at Community, works with facility discharge planning staff prior to discharge to assist Members in ensuring a safe transfer from an acute facility to the next level of care. The discharge planner or the Service Coordinator provide the current Individualized Care Plan (ICP) and other background information as appropriate to the receiving facility/Provider to assist in the smooth transition and care of the Member.

Case Management

- All Community Members enrolled in the Community Health Choice (HMO D-SNP) are enrolled in case management.
- Community performs a Health Risk Assessment within 90 days of enrollment, annually thereafter, and off cycle when the Member experiences a change such as a new diagnosis, an unplanned admission or a social change including loss of caregiver or loss of housing. The Health Risk Assessment is used to determine the Member's risk level and Individualized Care Plan (ICP).
- The ICP is composed of problems identified in the assessment process, goals related to each problem, barriers to achieving the goals, and specific interventions to mitigate the barriers.
- Case managers are registered nurses and licensed behavioral health clinicians, assigned based on the Member's primary needs and concerns. The case manager develops a preliminary care plan, based on the health risk assessment, and selects the Interdisciplinary Care Team (ICT) with the Member.
- The ICT includes the case manager, the Member, and the PCP. Additional Community staff such as a social worker or a pharmacist may be added to the ICT. A specialist may be added to the ICT while the Member is under treatment. The Member may request ICT Members such as a family member, caregiver, friend, neighbor, clergy or other individual who supports the Member with medical decisions or carrying out a treatment plan. The ICT reviews and approves the Individualized Care Plan and makes updates when indicated.
- The case manager distributes the care plan initially and when revised to ICT Members and schedules ICT meetings. When PCPs or specialty Providers are not able to attend ICT meetings, the case manager will seek input regarding the care plan prior to the meeting.
- Providers may contact our Care Management department at 832.CHC.CARE (832.242.2273) or 1.888.760.2600.

Quality Management

The clinical Quality Projects projected for the Members enrolled into Community Health Choice (D-SNP) program include the following:

- Improve 7- and 30-day follow-up appointments after hospitalization for mental Illness
- Improve Immunization rates for flu and pneumococcal
- Improve diabetic measures for Members with diagnosis of diabetes (A1C >7.5 and eye exam)
- Follow-up after ER visit for Members with multiple chronic conditions
- Community has designated improving access to ambulatory follow-up post hospitalization for mental illness as a Quality improvement Project that addresses consumer safety for all lines of business, including the Community Health Choice (HMO D-SNP) population.

Billing Information Reminders

- Submit Clean Claims within 95 days from the date of service
- Submit requests for payment disputes within 180 days from the date of disposition
- Rendering Provider NPI is required on all claims
- Provider must have CLIA certification on file with Community for CLIA-waived lab services
- Community utilizes Medicare edits and coding guidelines to ensure proper coding on health insurance claims

Hospice-Related Services

A Member who elects hospice care, but chooses not to disenroll from the health plan is entitled to continue to receive any covered benefits and services other than those that are the responsibility of the hospice.

Hospice provides services related to the treatment of the client's terminal illness and certain physician services (not including treatments).

Types of Service	Member Coverage Choice	Member Cost Sharing	Payment to Providers
Hospice Program	Hospice Program	Original Medicare cost-sharing	Original Medicare
Non-hospice care that are Medicare Parts A&B (medical & hospital) benefits	Community Health Choice or Original Medicare	If the Member follows the plan rules, the D-SNP cost sharing applies. If the Member does not follow the plan rules, Original Medicare cost sharing applies.	Original Medicare
Non-hospice care, Part D prescription benefit	Community Health Choice	D-SNP* cost sharing applies	Community Health Choice
Supplemental benefit under the D-SNP plan (that is above and beyond Original Medicare)	Community Health Choice	D-SNP* cost sharing applies	Community Health Choice

Sequestration

To comply with CMS' various payment methodologies, which includes sequestration, a 2% downward reduction to payments issued to contract and non-contracted Providers will be made.

- Community will adjudicate all claims to align with Medicare's reimbursement policies applicable to Provider payments with the sequestration methodology.
- Community will reduce by 2% payments made to Providers for items and services supplied to Community Health Choice (HMO D-SNP) Members.
- The Sequestration payment adjustment will be applied at the final payment level after all other edits, rules, and adjustments have been applied.

Payment Methods

Community partnered with Change Healthcare and ECHO Health, Inc. to provide electronic payment and reconciliation methods. Below we have outlined the payment options and any action items needed by your office:

- **Virtual Card Services** - If ECHO does not have a documented choice of payment for you, the default method of payment will be virtual card rather than a paper check. Virtual cards allow your office to process payments as credit card transactions and are generally received 7-10 days earlier than paper checks since there are no print or mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction, your Explanation of Payment (EOP), and an instruction page for processing. Once you receive the virtual card number, you simply enter the code into your office's credit card terminal to process payment as a regular card transaction. To avoid delays, please process the card or notify Change Healthcare/ECHO Health of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship. **NO ACTION IS NECESSARY to start receiving Virtual Credit Card payments.**

- **EFT/ACH** – Setting up electronic fund transfer (EFT) is a fast and reliable method to receive payment. If you would like to sign up for EFT, you have two options:
  1. To sign-up to receive EFT through Settlement Advocate for **Community Health Choice** only, visit https://view.echohealthinc.com/EFTERADirect/CommunityHealthChoice/index.html
  2. To sign-up to receive EFT from all payers processing payments on the Settlement Advocated platform, visit https://view.echohealthinc.com/EFTERA/efterainvitation.aspx. **A fee for this service may apply**.

- **Paper Check** – To receive paper checks and paper explanation of payments, you must elect to opt out of Virtual Card Services or remove your EFT enrollment.

Payment Methods (continued)

You can also log into www.providerpayments.com to gain online access to detailed explanation of payment for all ECHO transactions. If you wish, you can elect to receive an email notification each time Community Health Choice makes a payment to you.

If you have additional questions regarding your payment option, please contact **ECHO Health toll-free at 833-629-9725**.

Electronic Remittance Advice (ERA)

An ERA is an electronic file that contains claim payment and remittance information. It is often referred to by its HIPAA transaction number, 835.

ECHO Health can supply the hard copy ANSI 835 Enrollment Form.

You may access: https://view.echohealthinc.com/EFTERA/efterainvitation.aspx and select the option to enroll in an ERA only.

Claims Questions/Status

Providers can check claims status, Member eligibility, and a variety of other services online via our Provider Portal.

- You must sign up for this service. To learn more, visit www.CommunityHealthChoice.org/Medicare.
- To check status of a claim payment, authorized Providers can either:
  Contact Provider Hotline during regular business hours
  713.295.5007 or Toll-Free 1.833.276.8306

When contacting Provider Services, please be prepared to provide the following information:

- Name of the Provider
- Name of physician rendering the service
- Provider NPI number
- Provider Tax ID number
- Date(s) of service
- Amount of claim
- Member ID number and/or name
- Exact problem with claim

Provider Payment Disputes

Contracted Providers
do NOT have payment appeal rights.

A Contracted Provider may file
a **dispute** as outlined below.

Provider Payment Disputes

Community offers Providers a payment dispute resolution process.

A payment dispute is any claim payment disagreement between the healthcare Provider and for reason(s) including but not limited to:

- Denials for timely filing
- The failure of Community to pay on time
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a Provider
- Inappropriate or unapproved referrals initiated by Providers (i.e., a Provider payment dispute may arise if a Provider was required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim)
- Provider medical dispute without the Member's consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

No action is required by the Member. Provider payment disputes do not include Member medical appeals.

- Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 713.295.2295. Providers will not be penalized for filing a payment dispute. All information will be confidential.

- To submit a payment dispute, please send it to:

Community Health Choice
Attn: Claims-Provider Payment Dispute
2636 South Loop West, Ste. 125
Houston, TX 77054

Complaints

Members or Providers can submit a complaint at any time.

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a Provider or employee
- Failure to respect the Member's rights regardless of whether remedial action is requested

Community Health Choice
Service Improvement
2636 South Loop West, Ste. 125
Houston, TX 77054
Fax: 713-295-7036

ServiceImprovement@communityhealthchoice.org

Model of Care Training

Model of Care (MOC) training is a CMS requirement for newly contracted Medicare providers within 30 days of execution of contract with Community.

MOC training must be completed annually by each participating provider.

MOC information is available at:

https://providerportal.communityhealthchoice.org/Providers/Secure/ProviderTest_MCare_Content.aspx

THANK YOU

Community Health Choice appreciates all that you do for our Members!