## Contents

**Helpful Numbers and Information for STAR and CHIP** .......................................................... 10

**Introduction** .......................................................................................................................... 12
- About Community Health Choice ............................................................................. 12
- Pledge to our Providers ....................................................................................... 12
- Mission Statement .............................................................................................. 12
- Community Programs .......................................................................................... 12
- Community Service Area .................................................................................. 13
- Using the Provider Manual ............................................................................... 14
- Code of Ethics .................................................................................................. 14
- Health Insurance Portability and Accountability Act (HIPAA) Of 1996 ........... 15
- Provider Network Strategy .................................................................................. 15
- Provider Participation Criteria .......................................................................... 16
- Guidelines for Provider Communication and Interaction .............................. 17

**Provider Responsibilities** ......................................................................................... 18
- Primary Care Provider ......................................................................................... 18
  - Role of a Primary Care Provider (Medical Home) ........................................ 18
  - Primary Care Provider (Medical Home) Responsibilities .............................. 19
  - Preventive Health Services .......................................................................... 19
  - Primary Care Provider May Provide Behavioral Health Related Services Within the Scope of its Practice ......................................................... 19
  - Additional Community Primary Care Provider Responsibilities ................. 19
  - Specialist as “Principal” Care Physician ....................................................... 20
- Specialist Provider ............................................................................................... 22
  - Role of A Specialist Provider ....................................................................... 22
  - Specialist Provider Responsibilities ................................................................ 22
- Additional Provider Responsibilities (PCP and Specialist) ............................... 23
  - Member Information about Advance Directives .......................................... 23
  - Updates to Contact Information .................................................................. 23
  - Provider Plan Termination .......................................................................... 24
  - Member Eligibility Verification .................................................................. 24
  - Authorizations for Health Services ............................................................ 24
  - Standards for Medical Records .................................................................. 27
  - Coordination with Department of Family and Protective Services (DFPS) ........ 29
  - Provider Marketing Guidelines .................................................................. 29
  - Options for Member Non-Compliance .......................................................... 30
- Dispute Resolution for Providers ............................................................................ 31
  - Disputes Involving Administrative Matters .................................................. 31
  - Disputes Concerning Professional Competence or Conducts ..................... 31
  - Important Notes ......................................................................................... 32
- Forms for Providers ................................................................................................. 34
  - Member Education Request Form ............................................................... 34
  - Request for Member Reassignment Form ..................................................... 34
  - Provider Contact Information Update Form ............................................... 35
Authorization Form ................................................................... 36
Specialist Consultant Appointment Form .................................................. 38
Electronic Funds Transfer (EFT) Enrollment Form ........................................... 39
Electronic Remittance Advice (ERA) Form ................................................. 40

Access to Care ........................................................................... 41
Appointment Availability Requirements ..................................................... 41
Primary Care Provider 24-Hour Availability ................................................ 42
Network Referrals ........................................................................ 43
Network Limitations .................................................................... 43
Limited Provider Network (Applies to CHIP only) ........................................... 43
Referral to Ophthalmologist or Optometrist ............................................. 43
Network Pharmacy ..................................................................... 43
Community Members with Special Healthcare Needs .............................. 43
Referral to Specialists and Health-Related Services ........................................ 43
Specialist Scheduling Service ............................................................. 44
Referral to Network Facilities and Contractors ............................................. 44
Out-of-Network Referrals .............................................................. 44
Access to a Second Opinion ............................................................. 44
Continuity of Care ...................................................................... 45
Continuity of Care - Pregnant Woman Information .......................................... 45
Continuity of Care - Member Moves Out of Service Area ................................. 45
Continuity of Care - Pre-Existing Conditions ............................................... 45
Special Access Requirements ............................................................ 45
Interpreter/Translation Services ............................................................ 45
MCO/Provider Coordination ............................................................... 46
Reading/Grade Level Consideration ........................................................ 46
Cultural Sensitivity .................................................................... 47
Non-Emergency Transportation ............................................................. 47

Emergency Services .................................................................. 48
Emergency Room Services ................................................................ 48
Emergency Prescription Supply ............................................................ 48
Emergency Transportation ................................................................ 48
Emergency Dental Services ................................................................ 49
Medicaid Emergency Dental Services ..................................................... 49
CHIP Emergency Dental Services ........................................................ 49

Behavioral Health .................................................................... 50
Behavioral Health Provider Access Standards .............................................. 50
Primary Care Provider Requirements for Behavioral Health .......................... 50
Self-Referral ......................................................................... 50
Behavioral Health Services and Value-Added Services .................................. 50
Coordination Between Behavioral Health and Physical Health Services .............. 51
Medical Records Documentation ............................................................ 51
Consent for Disclosure of Information ........................................................ 51
Court-Ordered Commitments ............................................................... 51
Coordination with Local Mental Health Authority (LMHA) ........................... 51
Assessment Instruments for Behavioral Health: Beacon Health Options PCP Toolkit ............... 51
Major Depression Indicators ............................................................ 52
Substance Abuse Indicators ............................................................ 52
Inpatient Discharge Follow-Up and Missed Appointment Procedures ...................................................... 53
Physical Health Lab/Ancillary Tests ....................................................... 53
Behavioral Health Focus Studies and Utilization Management Reporting Requirements .......................... 53

Dental Services ........................................................................ 54
Role of Main Dental Home ............................................................... 54
How to Help a Member Find Dental Care ................................................... 54
Non-Emergency Dental Services. ........................................................ 54
Medicaid Non-Emergency Dental Services .................................................... 54
CHIP Non-Emergency Dental Services .................................................... 54

Pharmacy ........................................................................ 55
Role of Pharmacy. ....................................................................... 55
Pharmacy Provider Responsibilities ........................................................ 55
How to Find a List of Covered Drugs ..................................................... 55
How to Find a List of Preferred Drugs ..................................................... 55
How to Find a List of PA Required Services and Codes ............................ 55
Process for Requesting Prior Authorization ........................................... 56
Durable Medical Equipment and Other Products Normally Found in A Pharmacy (STAR) ..................... 56

Disease Management and
Complex Case Management. ............................................................ 57
Care Management/Disease Management Program ........................................ 57
Care Management/Disease Management at Community ..................................... 57
Care Management/Disease Management and Community Providers ..................... 57
Complex Case Management Program ...................................................... 58
Complex Case Management at Community ............................................... 58
Complex Case Management and Community Providers .................................. 58

Quality Management ........................................................................ 59
Clinical Practice Guidelines ............................................................... 59
Quality Improvement Program ............................................................ 59
Quality Improvement Principles .......................................................... 59
Quality Improvement Program Focus Areas ............................................. 59
Quality Improvement Studies ............................................................. 60
Utilization Management Reporting Requirements ......................................... 60

Billing and Claims ........................................................................ 61
Forms to Use ........................................................................ 61
Required Information for CMS 1500 Claims ........................................... 61
Required Information for UB-92/UB 04 Claim Forms ........................................ 62
Monthly Capitation Services ................................................................... 62
Reimbursement Methodology ............................................................... 62
Emergency Services Claims ................................................................... 62
Time Limit for Submission of Claims/Claims Appeals ..................................... 63
Clean Claims Payment ....................................................................... 63
Out-of-Network Provider Payments ....................................................... 63
Claims Filing ........................................................................... 63
Electronic Code Sets and Standard Transactions ........................................... 63
Electronic Medical Claims (Community) .................................................... 64
Electronic Behavioral Health Claims (Beacon Health Options) ...................... 64
Submitting Claims by Mail ........................................................................... 64
Claims Appeals .............................................................................................. 65
Claims Questions/Status ............................................................................... 65
Community Provider Portal ........................................................................... 66
Pharmacy Billing and Claims ......................................................................... 66
Billing Members ............................................................................................ 66
  Member Acknowledgement Statement ....................................................... 66
  Private Pay Form Agreement ..................................................................... 67
Reporting Provider or Recipient Waste, Abuse or Fraud .................................. 67
  Do you want to report Waste, Abuse, or Fraud? ......................................... 67
  To report waste, abuse or fraud, choose one of the following: ..................... 67

**STAR Program** ......................................................................................... 69

  STAR Program Objectives .......................................................................... 69
  STAR Covered Services ............................................................................... 69
    General Description .................................................................................. 69
    Prescribed Pediatric Extended Care Centers and Private Duty Nursing ....... 70
    Family Planning ....................................................................................... 70
  Texas Health Steps ..................................................................................... 71
  THSteps Goals ............................................................................................ 71
  THSteps Services ........................................................................................ 71
    Periodicity Schedule ................................................................................ 71
    Role of Texas Health and Human Services Commission (HHSC) THSteps Staff 74
    Referral Guidelines ................................................................................. 74
    Reimbursement for Medical Checkups ...................................................... 74
    Documentation of completed Texas Health Steps components and elements 75
    Laboratory Tests ...................................................................................... 76
    THSteps Provider Responsibilities ............................................................ 76
    THSteps Screenings for Newborns ............................................................. 76
    Reporting Immunizations ....................................................................... 77
    THSteps Vision Screen .............................................................................. 77
    THSteps Comprehensive Care Services .................................................... 78
    Community Panel Report ....................................................................... 78
  Coordination with Non-Health Plan Covered Services .................................... 81
    THSteps Dental Services .......................................................................... 81
    THSteps Environmental Lead Investigation (ELI) ...................................... 81
    Texas Agency Administered Programs and Case Management Services ...... 81
    Essential Public Health Services ............................................................... 81
    Texas School Health and Related Services (SHARS) ................................. 82
    Early Childhood Intervention (ECI) Case Management/Service Coordination 82
    Early Childhood Intervention Specialized Skills Training .......................... 82
    Mental Health Rehabilitative (MHR) And Targeted Case Management (TCM) 82
    Case Management for Children and Pregnant Women (CPW) ................... 83
CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinates .......................... 139
Behavioral Health ................................................................. 141
CHIP Perinatal Program Covered Services for CHIP Perinatal Newborns 186% to 200% FPL .... 141
CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinatal Newborns ........ 152
Coordination with Non-CHIP Covered Services ................................................................. 157
Texas Agency Administered Programs and Case Management Services .......................... 157
Essential Public Health Services ................................................................. 157

**CHIP Perinatal Complaints and Appeals** ................................................................. 158
CHIP Perinatal Provider Complaints and Appeals .......................................................... 158
Key Terms to Understand ...................................................................................... 158
CHIP Perinatal Provider Complaints Process .............................................................. 158
CHIP Perinatal Provider Appeals Process ..................................................................... 158
CHIP Perinatal Member Complaints and Appeals ........................................................ 160
Member Complaints Process .................................................................................... 160
Standard Member Appeals Process ............................................................................ 162
 Expedited Member MCO Appeal ............................................................................. 163

**CHIP Perinatal Member Eligibility** .......................................................................... 166
Eligibility .................................................................................................................. 166
Verifying Eligibility ................................................................................................. 166
CHIP Perinatal Member ID Cards ............................................................................. 167
Application Assistance ............................................................................................. 167

**CHIP Perinatal Member Rights and Responsibilities** ................................................. 168
Member Rights ........................................................................................................ 168
Member Responsibilities ........................................................................................... 168
Reporting Provider or Recipient Waste, Abuse or Fraud by A Provider or Client ............ 169
CHIP Perinatal Member Cost Sharing Schedule ......................................................... 169
Billing Members ....................................................................................................... 170
Member’s Right to Designate An OB/GYN .................................................................. 170
CHIP Member Enrollment and Dis-Enrollment from Community ............................... 170
Enrollment ................................................................................................................. 170
Disenrollment ............................................................................................................ 170
Plan Changes ............................................................................................................. 171
**HELPFUL NUMBERS AND INFORMATION FOR STAR AND CHIP**

| Provider Relations | For general questions or to submit your updates:  
|  | 713.295.2294 or Toll-Free 1.888.760.2600  
|  | www.CommunityHealthChoice.org  
|  | ProviderRelations@CommunityHealthChoice.org  
|  | Or contact your Provider Relations Representative |
| Claims Inquiries or Adjudication | CommunityHealthChoice.org  
|  | 713.295.2295 Toll-free 1.888.760.2600  
|  | Community will accommodate three claims per call. Unlimited inquiries on Web site. |
| Mailed Claims | Community Health Choice  
|  | Attn: Corrected Claims | P.O. Box 301404 | Houston, TX 77230 |
| Refund Lockbox | Amegy Bank  
|  | P.O. Box 4605 | Houston, TX 77210-4605 |
| Electronic Claims | Submit directly through Community’s online claims portal:  
|  | CommunityHealthChoice.org > Provider Tools > Claims Center  
|  | Payer ID: 48145  
|  | Change HealthCare Solutions, Inc. (Formerly Emdeon) 1.800.735.8254  
|  | AVAILITY 1.800.282.4548  
|  | RelayHealth 1.563.585.4411  
|  | Gateway/Trizetto Provider Solutions 1.800.969.3666  
|  | TMHP (STAR only) www.tmhp.com |
| Peer-to-Peer Discussions | 713.295.2319 |
| Utilization Management | Phone: 713.295.2221 Fax: 713.295.2283 or 84 |
| Care Management/Disease Management: Asthma, Diabetes, High-Risk Pregnancy, Congestive Heart Failure | Phone: 832.CH.CARE (832.242.2273)  
|  | E-mail: CMCoordinators@CommunityHealthChoice.org  
|  | Fax: 713.295.7028 |
|  | 713.295.2303 Toll-free: 1.888.760.2600 | Fax: 713.295.7028 |
| Diabetic Supplies/Outpatient Perinatal | Fax: 713.295.7028 | Toll-free fax: 1.844.247.4300 |
| Adverse Determination and Appeals | Community Health Choice  
|  | Attn: Appeals  
|  | 2636 South Loop West, Suite 125 | Houston, TX 77054  
|  | All appeals must be in writing and accompanied by medical records. |
| Member Services and Specialist Scheduling | 713.295.2294 or 1.888.760.2600  
|  | • Benefit coverage and eligibility verification  
|  | • Physician information  
|  | • Service questions  
|  | • Interpreter Services  
|  | • Specialist Referral Assistance |
| Pharmacy | Navitus Health Solutions  
|  | 1.877.908.6023 | www.navitus.com |
| Behavioral Health | Beacon Health Options  
<p>|  | 1.877.343.3108 | <a href="http://www.beaconhealthoptions.com">www.beaconhealthoptions.com</a> |</p>
<table>
<thead>
<tr>
<th>Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members can go to any of these preferred laboratories:</td>
</tr>
<tr>
<td>• Clinical Pathology Laboratories, Inc.</td>
</tr>
<tr>
<td>• LabCorp</td>
</tr>
<tr>
<td>• Medical Diagnostic Laboratories, LLC</td>
</tr>
<tr>
<td>• Quest Diagnostics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For STAR Members through the month of their 21st birthday</strong></td>
</tr>
<tr>
<td>DentaQuest: 1.800.516.0165</td>
</tr>
<tr>
<td>MCNA Dental: 1.800.494.6262</td>
</tr>
<tr>
<td><strong>For STAR Members 21 years of age and over</strong></td>
</tr>
<tr>
<td>STAR Dent: 1.866.844.4251</td>
</tr>
<tr>
<td><strong>For CHIP Members</strong></td>
</tr>
<tr>
<td>DentaQuest: 1.800.516.0165</td>
</tr>
<tr>
<td>MCNA Dental: 1.800.494.6262</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Envolve Vision</td>
</tr>
<tr>
<td>Toll free: 1.800.334.3937</td>
</tr>
<tr>
<td><a href="https://visionbenefits.envolvehealth.com">https://visionbenefits.envolvehealth.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Early Childhood Intervention (ECI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DARS Toll-free: 1.800.628.5115</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Transportation Program (STAR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Transportation Program (State Controlled)</td>
</tr>
<tr>
<td>Medical Transportation Management (MTM)</td>
</tr>
<tr>
<td>Toll-free: 1.855.687.4786</td>
</tr>
<tr>
<td>Monday-Friday 8 a.m. to 5 p.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAR Program Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll-free: 1.800.964.2777</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHIP Application and Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll-free: 1.800.647.6558</td>
</tr>
</tbody>
</table>
Introduction

About Community Health Choice

Community Health Choice (Community) is a local non-profit health plan, a licensed Health Maintenance Organization (HMO) providing services to Texas STAR, CHIP, and CHIP Perinatal Members. At Community, we genuinely CARE for and SERVE our Community. We are a TRUSTED partner who RESPECTS our Members and their families, opens doors to high-quality healthcare, and makes the process EASY. Even more simply, we say Community Cares.

This manual is intended to support Providers and contracted entities. Community is sensitive to the demands on the Provider’s time and resources and is dedicated to offering the support needed by streamlining our administrative procedures.

Pledge to our Providers

To the Providers, Community pledges:

- Easy access to Community staff via the Web site, by phone or by personal visit from your assigned Provider Engagement Representative
- Fair and timely payment of clean claims
- Provider education and office staff training programs
- Active Care Management programs for chronic diseases such as asthma, diabetes or high-risk pregnancy (specifically diabetes, hypertension, previous preterm birth or multiples)
- Complex Case Management for complex comorbid conditions such as Traumatic Brain Injury, Cancer, End Stage Renal Disease, Multiple Trauma, and Spinal Cord Injuries
- Communication on a regular basis that alerts Providers to upcoming events and initiatives sponsored by Community
- Frequently updated Quick Reference Guides available on Community’s website

Mission Statement

At Community, our mission is to improve the health and well-being of underserved residents of Southeast Texas by opening doors to coordinated, high-quality, affordable health care and health-related social services. Our mission is achieved through:

COMMUNITY: Collaborating with community-based Providers and organizations to improve access, quality, coordination and cost effectiveness of services.

HEALTH: Developing programs to establish medical homes, manage health conditions, and promote wellness and preventive care.

CHOICE: Encouraging personal accountability and educated choices for individual and family health and well-being

Community Programs

Community serves nearly 350,000 Members through the following programs:

- Children’s Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits of unborn children.
- Health Insurance Marketplace Plans for individuals, including plans with subsidized premiums for lower income families.
- Regional HMO coverage for State of Texas employees.
- Administrator for multiple collaborative safety net projects, including Delivery System Reform Innovation Projects (DSRIP), Network Access Improvement Program (NAIP) and others.
Using the Provider Manual

The Provider Manual is designed as an informational and procedural guide for Community Participating Providers and their staff, for Community’s contracted facilities, and for Community’s ancillary Providers. The manual contains instructions, quick reference guides, and Community policies and procedures that will assist Providers and their staff’s interaction with Community. When followed, this manual will decrease the paperwork and time your staff spends:

- Researching details of STAR, CHIP, and CHIP Perinatal programs
- Obtaining prior authorizations for certain services
- Re-billing corrected claims
- Appealing adverse determinations

Material in this Manual is subject to change. The most recent information is also available on our Web site at www.CommunityHealthChoice.org. Updates and new services may be added periodically to the Manual. Community will post the revised information on our Web site from which you can print the revisions, if desired. Likewise, when Community develops new policies/procedures or clinical practice guidelines, Community will post the most current versions on our Web site and alert Providers of their availability. Community will distribute a copy of the new policy, procedure or guideline, upon request.

You can request copies of the Provider Manual, by calling 713.295.2295 or from your Provider Engagement Representative.

The Provider Manual is designed solely as a guide. If differences, errors or omissions occur between this manual and either the Provider’s contract or the HHSC policies and regulations, the Provider contract and HHSC policies and regulations shall govern. The Community Provider Manual does not supersede or amend, in any manner, the contractual obligations of either Community or the Provider to HHSC.

As an additional reference, Providers may use the Texas Medicaid Provider Manual online at www.TMHP.com. This Web site provides the most current information about Texas Medicaid benefits, policies, and procedures. It also contains the most recent updates in the Medicaid Provider Bulletins section, released every other month.

Code of Ethics

Community is committed to providing access to a quality network and healthcare delivery systems that provide healthcare in a manner that preserves the dignity, privacy, and autonomy of the Members.

To further this goal, Community Network Providers shall:

- Treat all Members with respect and courtesy
- Respond promptly to Members’ questions
- Ensure that Members have reasonable access to the services to which they are entitled under their health plan
- Assist Members (or their legal guardians, when appropriate) with making informed decisions about their medical care, including providing them with information about withholding resuscitative services, foregoing or withdrawing life-sustaining treatment or participating in studies or clinical trials. Providers, as required by law, shall obtain informed consent
- In making clinical decisions concerning a Member’s medical care, a Community Network Provider shall not allow him/herself to be influenced by how the Provider or Provider network is financially compensated or by whether a particular treatment or course of care would be covered by the Member’s plan.
- Avoid conflicts of interest. Network Providers making clinical decisions concerning a Member’s medical care should not be influenced by any financial interest they may have in any entity to which the Member has been or may be referred
- Maintain the confidentiality, as required by law, of information concerning Members’ medical care and health status
- Cooperate with Quality Improvement activities
Health Insurance Portability and Accountability Act (HIPAA) Of 1996

Electronic Code Sets and Standard Transactions

Federal regulations require covered entities (HMOs, physicians, hospitals, labs, pharmacies and other healthcare Providers) to comply with HIPAA-approved transactions and code sets for dates of service on or after October 16, 2003.

Privacy and Security Statement

As covered entities under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and its associated regulations, Community and all Providers and clearinghouses must adhere to “Protected Health Information,” and “Individually Identifiable Health Information” requirements as those terms are defined in the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (“HIPAA”), HIPAA regulations (codified at 45 C.F.R. Parts 160 and 164) or in regulations on Standards for Privacy of Individually Identifiable Health Information, including the HITECH Act.

One of the requirements of the HIPAA Privacy Rule is for covered entities to issue a Privacy Notice. The HIPAA Privacy Notice is on our Web site at www.CommunityHealthChoice.org.

Provider Network Strategy

Community Executives agree that high-value healthcare is only achievable if improvement initiatives pursue a broader system of linked goals, which in the aggregate represent the Centers for Medicare and Medicaid Service’s “Triple Aim”: (1) improving the individual experience of care; (2) improving the health of populations, and (3) reducing the per capita costs of care for populations.

To remain in alignment with the Triple Aim initiatives, and as a springboard to ensuring laser-focus and consistency in the development and implementation of all future Provider initiatives, Community Executives discussed, debated, and reached unanimous agreement with the following over-arching principles governing Community’s Provider Network Strategy:

- Provider participation criteria will extend beyond the any willing Medicaid provider approach.
- Continuous monitoring and reporting on network adequacy & competitiveness; assessing various Access & Availability metrics defined & published by State, Regulatory, and Accreditation entities.
- Definitive, published Network Participation Criteria for Physicians, Hospitals, and Ancillary Providers.
- A staunch commitment to Quality and belief that Quality cost less, as evidenced by the inclusion of various quality as well as efficiency metrics in its Network Participation Criteria.
- A belief that Primary Care Physicians should serve as medical homes accountable for the Members’ overall healthcare needs, and fair compensation is paramount in those efforts.
- Transition from the traditional relationship between Health Plan & Providers as buyers and vendors, to true long-term collaborative and synergetic partnerships, through formal & continual efforts to:
  1. maintain full transparency in communication
  2. eliminate administrative burdens or expense for all parties whenever feasible,
  3. design and implement innovative provider compensation methodologies
  4. allow direct provider input in operational decision-making throughout the organization
  5. preserve long-term commitment to Provider Incentive programs offering both monetary and non-monetary rewards for high quality and performance excellence.
- Community fully embraces a Pay-for-Performance philosophy, with focus on more of a “carrot” versus “stick” approach in terms of quality performance programs.
- Heightened and continual focus on alignment of shared goals of Members, Providers, and Community through development and on-going improvement of a formal Provider Engagement Program offering a continuum
of programs to match each individual provider’s own personal Quality journey experience, enhancing overall performance and strengthening network retention.

**Provider Participation Criteria**

Provider Participation Criteria is one of the key components of Community’s Provider Engagement Platform (see Q1-2014 Newsletter). Currently, Community maintains Provider Participation Criteria for Physicians and for Ancillary Providers. Community continues efforts to improve its own operations and to assess and support the quality and administrative efficiency of its Participating Providers. Community will develop and publish Participation Criteria for additional Provider types in the near future.

**Physician Participation Criteria**

The following Participation Criteria applies to all Physicians participating in Community’s provider network(s), subject to exception based on Community’s sole discretion; e.g. unique geographic or demographic circumstances or specific member access and availability needs. Physicians currently participation in Community’s provider network(s) who may be in the process of recruiting additional Physicians: Please note that such Physicians may be excluded from participation if they do not meet the Physician Participation Criteria.

<table>
<thead>
<tr>
<th>Criteria Type</th>
<th>Criteria</th>
<th>Regulatory</th>
<th>Administrative</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation in THSteps Program</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Attested NPI Number</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Valid Medicare Number (preferred)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Not currently on any government exclusion list</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Internet access at office/patient care setting</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Fax availability at office/patient care setting</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Hospital Privileges at a Participating Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Electronic Claims Submission</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Electronic Funds Transfer (EFT)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Electronic Remittance Advice (ERA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Adherence to HIPAA Standard Transactions</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Participation in CAQH Program</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Board Certification</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Signed Commitment to Quality Statement</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Applies to PCP Providers only*

*Does not apply to Pediatric or OB/GYN Providers.*

*Or advanced approval of acceptable coverage (e.g. Hospitalist agreement)*

*Through existing clearinghouse partnerships*

*Existing Providers who are Board eligible will need to pass their Board by their re-credentialing date*

*Applies to PCPs and OB/GYNs only.*
Ancillary Participation Criteria

The following Participation Criteria applies to all Ancillary Providers in Community’s provider network(s), subject to exception based on Community’s sole discretion; e.g. unique geographic or demographic circumstances or specific member access and availability needs.

<table>
<thead>
<tr>
<th>Criteria Type</th>
<th>Criteria</th>
<th>STAR</th>
<th>CHIP</th>
<th>HIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>Has valid Medicaid Number</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Administrative</td>
<td>Has at least one line dedicated to facsimile</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administrative</td>
<td>Submits authorizations electronically (via Provider portal)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administrative</td>
<td>Accepts Electronic Remittance Advice (ERA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administrative</td>
<td>Accepts Electronic Funds Transfer (EFT)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Quality</td>
<td>Use of a reasonable Patient Satisfaction Survey and demonstrated action based upon prior year or year’s results, as determined by Community</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Quality</td>
<td>Must have valid Medicare Number (required)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guidelines for Provider Communication and Interaction

Community established internal guidelines for all staff regarding communication and interaction with Network Providers to ensure the daily application of the principles outlined in its Provider Network Strategy Statement. These internal guidelines shall be incorporated into a specific employee Policy and Procedure and employee annual training. The guidelines spell out how staff can demonstrate compliance with the following over-arching communication and interaction principles:

• Community staff will always make best efforts to ensure full transparency with Network Providers;
• Community staff will whenever possible, solicit input from Community’s Provider Engagement Panel prior to implementation of a new policy, program, etc.;
• Community staff will notify Network Providers in advance of operational or administrative changes that may impact a Provider’s office, particularly those that directly impact a Provider’s compensation, including revision to a claims payment methodology or changes in requirements for Prior Authorization;
• Community staff will directly communicate with its Network Providers and not rely on any third party’s communications with those Providers; and
• Community staff will whenever possible, propose solutions to reward desired behavior rather than penalties for non-desired behavior.
Provider Responsibilities
Primary Care Provider

Role of a Primary Care Provider (Medical Home)

HHSC and DSHS encourage Providers participating in the STAR and CHIP Programs to practice the “Medical Home” concept. To realize the maximum benefit of healthcare, each family and individual needs to be a participating member of a readily identifiable, community-based Medical Home. The Medical Home provides primary medical care and preventive health services and is the individual’s and family’s initial contact point when accessing healthcare. It is a partnership among the individual and family, healthcare Providers within the Medical Home, and the extended network of consultative and specialty Providers with whom the Medical Home has an ongoing and collaborative relationship. The Providers in the Medical Home are knowledgeable about the individual’s and family’s specialty care and health-related social and educational needs, and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, specialty/hospital services, and health-related services, the Medical Home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the Medical Home for continuing primary medical care and preventive health services.

Primary Care Providers may include the following specialties:

- General Practitioners
- Family Practitioners
- Internists
- Pediatricians
- Obstetricians/Gynecologists (OB/GYN)
- Federally Qualified Health Center (FQHC)
- Pediatric and Family Advanced Nurse Practitioners (FANP)
- Certified Nurse Midwives (CNM)
- Rural Health Clinics (RHC)
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Specialist (for Members with special medical needs)

Member’s Right to Designate an OB/GYN as their Primary Care Provider

Community Members have the right to designate an OB/GYN as their primary care provider if the OB/GYN elects to be a Primary Care Provider.

Role of CHIP Perinatal Provider (for CHIP Perinatal only)

CHIP Perinatal providers provide pregnancy services, since benefits are limited to prenatal care. CHIP Perinatal members will have a perinatal care provider. Perinatal care providers include:

- Family Practitioners
- Obstetrician/Gynecologists
- Internists
- Advanced Nurse Practitioners (ANP)
- Certified Nurse Midwives (CNM)
- FQHC Clinics
- RHC Clinics
Primary Care Provider (Medical Home) Responsibilities

The Primary Care Provider either furnishes or arranges for all the client's healthcare needs, including well checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

Community STAR and CHIP Members must select a Primary Care Provider. If a Member does not select a Primary Care Provider, Community will auto-assign the Member to a physician based on the Member’s home address and any prior Member/Provider relationships. The Primary Care Provider will furnish primary care-related services, arrange for and coordinate referrals for all medically-necessary specialty services, and be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, seven days a week. Primary care includes ongoing responsibility for preventive healthcare, health maintenance, treatment of illness and injuries and the coordination of access to needed specialist Providers or other services.

Providers serving in the role of PCP are responsible for:

- Providing primary healthcare services, including preventive care and care related to common or routine illness, and educating patients and their families regarding their medical needs
- Referring Community Members to other Participating Providers and facilities for needs other than primary healthcare services (Referrals to Specialty Providers must be made within 24 hours for urgent care and within two weeks for routine care)
- Coordinating utilization of services and monitoring the progress of care to facilitate the return to the Primary Care Provider as soon as medically appropriate
- Complying with the Community's Commitment to Quality for Primary Care, as well as other Quality Improvement Programs, which may include period chart reviews
- Maintaining an open panel for Membership
- Cooperating with Community's Care Management Program by providing clinical information when necessary and participating in care plan development for Community Members with chronic diseases

Preventive Health Services

Providers must provide preventive health services in accordance with the STAR/CHIP programs and related medical policies. The preventive health services shall include, but are not limited to, the following:

- Adherence to Texas Health Steps (THSteps) periodicity schedule for STAR and AAP Guidelines for CHIP
- Annual well checkups for all adult Community Members over the age of 21
- Immunizations, TB screenings and other measures for the prevention and detection of disease, including instructions in personal healthcare practices and information on the appropriate use of medical resources
- Education of Members about their right to self-refer to any Network OB/GYN Provider for OB/GYN health-related care

Primary Care Provider May Provide Behavioral Health Related Services Within the Scope of its Practice

Primary Care Providers must screen, evaluate, refer and/or treat any behavioral health problems and disorders for Community Members. The Primary Care Provider may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues.

Additional Community Primary Care Provider Responsibilities

- Contact Community to verify Member eligibility prior to providing covered services
- Maintain confidentiality of Personal Health Information (PHI) for Community Members
- Provide telephonic access to Community Members during normal business hours and provide for coverage of after-hours medical emergencies
- Provide or arrange for routine medically-necessary care within two weeks of a request and for urgent care within 24
hours of the request

- Maintain an open panel for Community Membership that conforms to HHSC guidelines
- Maintain staff membership and admission privileges in good standing with at least one hospital contracted with Community, unless otherwise approved
- Be aware of culturally sensitive issues with Members
- Ensure written materials given to Members are on a 4th- to 6th-grade reading level
- Provide care to eligible children who are receiving service from or have been placed in the conservatorship of Texas Department of Family and Protective Services (DFPS)
- Agree not to refer or direct patients to hospital emergency rooms for non-emergent medical services at any time
- Assist in educating and instructing Community Members about the proper utilization of Provider office visits in lieu of the emergency room
- Maintain both general liability and professional liability insurance of a type, and in the amounts acceptable, to HHSC as specified in the HHSC Uniform Managed Care Contract
- Meet all Community credentialing and re-credentialing requirements
- Permit release of confidential information only under circumstances described in the HHSC Medicaid Provider Procedures Manual
- Submit and maintain claims using the assigned Community Provider and referral authorization number
- Maintain all medical records relating to Community Members for a period of at least five years from the initial date of service
- Comply with federal regulations that protect against discrimination and the federal Americans with Disabilities Act (ADA)
- Maintain any and all licenses in the State of Texas as required by the laws governing his/her profession or business
- Notify Community of any policy or procedure that creates a barrier to care

**Specialist as “Principal” Care Physician**

Specialist physicians may be designated as the “Principal” Care Physician or Medical Home for a Community Member with a very complex, multi-system disease, or with chronic conditions and who requires a level of service coordination and technology that are beyond the scope and role of a general practitioner as defined by URAC, MCG Healthcare Management Guidelines and/or Community’s Medical Care Management Committee. Community’s designation of a “Principal” Care Physician requires prior authorization. Authorization may be given for up to one year. All authorizations will be recorded in the Community claim system authorization module, which will be queried when claims are processed.

Specialists who become a “Principal” Care Physician must meet and adhere to the following criteria as they manage the care to Members with complex conditions:

- Actively participate in the Case Management Program
- Have demonstrated expertise in treating a particular disease and/or condition
- Agree to abide by Community policies and procedures
- Agree to provide primary care according to primary care standards
- Agree to participate in the development of medical management and treatment guidelines
- Agree to provide 24-hour, seven-day-a-week, on-call coverage through a system staffed by other similarly-qualified physicians

The case manager, Primary Care Provider or specialist may request health services authorization of the specialist as the designated “Principal” Care Physician for a Member with complex medical issues by providing the following information:

- Patient’s full name
- Secondary diagnosis
• Age
• Highlights of medical history
• Sex
• Identification of all physicians involved in the care of the patient and scope
• Primary diagnosis
• Rationale for request

The specialist must be approved by the Medical Director. The specialist must sign a statement stating that he/she is willing to accept responsibility to serve as the Member’s Primary Care Provider and accept Community’s reimbursement for non-specialty, Primary Care Provider-related services. The Member must sign a statement indicating consent for the specialist to serve as Primary Care Physician. The Medical Director of Community will approve or deny the request for special consideration as previously outlined in this section and provide written notification of the decision to the enrollee, no later than 30 days after receiving the request. If the request is denied, Community will provide written notification to the Member including the reason(s) for the denial along with information on how to appeal the decision through the complaint and appeals process.

The Medical Director will consult and communicate directly with both the original Primary Care Provider and the specialist being designated as the “Principal” Care Physician to explore and suggest other alternatives and communicate his/her decision on the case.

The specialist designated as the “Principal” Care Physician will continue to collaborate closely with the case manager for intensive case management for Members and their significant others.

The “Principal” Care Physician will be responsible for keeping the original Primary Care Provider informed about the patient’s condition and progress. The effective date of the non-primary physician will be the day it is approved by Community’s Medical Director. The effective date may not be applied retrospectively. The Medical Director will receive a monthly update from the case manager on the Member’s condition to evaluate the continued appropriateness of this arrangement. The specialist will remain as the “Principal” Care Physician designee as long as the patient’s needs warrant this level of expertise and meet Community policy. Annual authorization is required.

Compensation owed to an original Primary Care Provider may not be reduced prior to the effective date of the designation of the specialist as “Principal” Care Physician.

Community’s Medical Care Management Committee (MCMC) will review these cases regularly. The “Principal” Care Physician may be asked to respond to specifics about the case and should be willing to respond in a timely manner. All exceptions to this policy will be considered by the Community Medical Director in conjunction with other Members of Community’s MCMC, as deemed necessary.

Community is required to report to HHSC, on a quarterly basis, the number of specialists performing Primary Care Provider functions under the STAR program including, but not limited to, the number and nature of complaints about these specialists.
Specialist Provider

Role of A Specialist Provider

Specialist Providers are responsible for treating Members who have been referred to them by participating Primary Care Providers. Specialists should:

- Provide specialty services upon referral from the Primary Care Provider
- Work closely with the Primary Care Provider to enhance continuity in health services to Community Members
- Advise the Primary Care Provider in writing regarding findings in a consultation, recommendations or an ongoing treatment program
- Notify the Primary Care Provider if another specialist is needed
- Send a referral form to any additional, in-network specialist before sending Member to an out-of-network provider
- Notify the Primary Care Provider and Community when a specialist wants to admit a Member to a hospital, and relay information necessary to authorize the admission. Community does not require pre-authorization for in-network specialists to treat Members.

Please confirm Member eligibility by calling Community Member Services at 713.295.2294 or 1.888.760.2600 or access eligibility information on our Web site at www.CommunityHealthChoice.org. A copy of the Primary Care Provider referral should be placed in the Member’s medical record.

Please confirm the specialist’s network status by calling Community Member Services.

Specialist Provider Responsibilities

Specialists are responsible for furnishing medically-necessary services to Community Members who have been referred by their Primary Care Provider for specified consultation, diagnosis and/or treatment. The specialist must communicate with the Primary Care Provider regarding services rendered, results, reports and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the Primary Care Provider. The specialist should also respond to requests from the Community Health Services Department for pertinent clinical information that assists in providing a timely authorization for treatment.

Community Members are assured timely access to services and availability of specialty Providers within the established standards. When a Community Member receives a specialist referral from his/her Primary Care Provider, the specialist should review the case with the Primary Care Provider to determine clearly what services are being requested. Referrals from the Primary Care Provider must be documented in both the Primary Care Provider’s and the specialist’s record and must be provided within 21 days of request. Referrals to a specialist cover the time and treatment specified.

To authorize services, please call 713.295.2295, fax 713.295.2283 or submit an authorization online at www.CommunityHealthChoice.org.

Claims submitted for services by specialists for Community Members should reference the Primary Care Provider assigned nine-digit Medicaid Provider number as the referring Provider (Block 17A of the CMS 1500 claim form).

Provider shall maintain such offices, equipment, patient services personnel and allied health personnel as may be necessary to provide contracted services. If the Provider is a Specialty Care Physician, the Provider shall ensure that contracted services are provided under this agreement at the Specialty Care Physician’s office during normal business hours, and be available to beneficiaries by telephone 24 hours a day, seven days a week for consultation on medical concerns.
Additional Provider Responsibilities (PCP and Specialist)

Member Information about Advance Directives

With advances in medical technology, physicians and the healthcare team have the ability to save the life of a person who would not otherwise have the chance to live. While this is a benefit to many people, it has also caused problems for the patients and/or families of those who are terminally ill or have irreversible injuries. By prolonging their life, it also prolongs the process of dying.

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. The Member’s wishes can be recorded on a document called a “Directive to Physician” or indicated by providing a “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. The Member can create a document called a “Declaration for Mental Health Treatment.” All Community Members have the right to informed choices and to refuse treatment or therapy.

Community Members have the right to be informed of their health condition, consent diagnosis, prognosis, and the expected results and associated risks of certain diagnostic, treatment and therapeutic choices. Community recognizes the right of every individual to self-determination concerning his/her own body. This right may prevail even when the decision of the individual is considered to be unwise or contrary to the individual’s best medical interest. Community physicians have a duty to respect this right and must work within the scope of authorized patient consent. Any time there are risks involved, participating physicians should obtain the informed consent of the Member, in addition to the required permissive consent.

Members may be terminated from Community if there are repeated incidents of unreasonable refusal of a Member to follow a prescribed course of medical treatment. In such instances, the physician should contact the Community Medical Director to discuss the course of action. Community strongly recommends that Providers encourage Members to complete an advanced directive.

Updates to Contact Information

Please contact Community Provider Relations and THMP in writing to report any of the following changes:

- Name
- DPS number
- Address
- Permit to practice
- Office hours
- Professional liability insurance
- Coverage procedures
- Limits placed on practice
- Corporate number
- Status of hospital admission
- Telephone number
- Contract status change
- Specialty change
- Opening/closure of panel
- Tax ID number
- Patient age limitations
- Medicaid Provider number
- DEA number
- NPI number
- TPI number
- Group affiliations
- Other information that may affect current contracting relationship
- Addition of any practice and closure of address
- New Physician, Nurse Practitioner or Physician Assistant
- Termination of any Physician, Nurse Practitioner or Physician Assistant in Physician’s practice

Providers have a maximum of 30 calendar days to inform Community and TMHP of any changes to the Provider data listed above. Changes not received in writing are not valid. If Community is not informed within the aforementioned timeframe, Community and its designated claims administrator are not responsible for the potential claims processing and payment errors. Send notification of changes to:
Changes should also be forwarded to TMHP to ensure that all claims and assignments will be permitted by TMHP. Send changes to:

Provider Enrollment
TMHP
P.O. Box 200795
Austin, TX 78720-0795
Web site: www.TMHP.com

Send changes in provider information for behavioral healthcare providers to:

Beacon Health Options Provider Operations Department
Phone: 1.877.490.6854
Fax: 1.866.464.7534

Provider Plan Termination

Providers who elect to terminate Community participation must, themselves or their respective IPA, notify Community Provider Relations by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of your contract with Community or your IPA. Community will notify the Member in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the preceding month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Community to efficiently transfer patients to another Provider. Physicians are requested to continue care in progress until all Members can be successfully transferred to new Primary Care Providers.

Member Eligibility Verification

It is the responsibility of the treating Provider to verify that the patient continues to be a Community and a STAR or CHIP eligible Member during the treatment period. Information about eligibility verification can be found in the STAR, CHIP, and CHIP-Perinatal sections of this manual or call Community Member Services at 713.295.2294 or 1.888.760.2600.

Authorizations for Health Services

Prior Authorization

Prior authorization (sometimes referred to as pre-certification or pre-notification) determines whether medical services are as follows:

- Medically Necessary
- Experimental/Investigational
- Provided in the appropriate setting or at the appropriate level of care

Prior authorization is not a guarantee of payment. Regardless of whether a Provider obtained the required prior authorization, Community must process a Provider’s claim according to eligibility, contract limitations, and benefit coverage guidelines. Community will determine payment at the time Community receives a Provider’s claim.

Services Requiring Authorization

The list of services requiring a prior authorization is on the Prior Authorization guide located on the Provider Portal, at
Effective January 2015, the following services require authorization:

Admissions to facilities (including transfers between separate facilities)
- Surgical and nonsurgical
- Rehabilitation facility
- Skilled Nursing facility
- Inpatient hospice
- Maternity and newborn stays that exceed two days for vaginal delivery or four days for Cesarean section delivery

Ambulance/Transport
- In and out-of-area
- Non-Emergency ground and air
- Facility to facility transfers

Bariatric Surgery

Behavioral Health Services (including substance abuse)
- Health Insurance Marketplace
  - Call Beacon Health Strategies at 1.855.539.5881
- Medicaid and CHIP
  - Call Beacon Health Strategies at 1.877.343.3108

Cardiac Services
- Cardiac imaging
  - Nuclear studies (including stress tests)
  - Echocardiograms (transthoracic and/or transesophageal, including stress testing)
  - Cardiac MR, MRA, CT, CTA, PET or PET/CT
  - Electron-beam CT/calcium scoring

Chemotherapy and office/outpatient use of biological, immunotherapy medications - including, but not limited to:
- Actimmune®, Acthar® Gel; Adcetris™; Alpha 1-proteinase inhibitor; Antiemetics - Palonosetron (Aloxi IV®), dolasetron (AnzemetIV®) and fosaprepitant (Emend1IV®); Benlysta; Botulinum toxin type A and B (Botox®, Dysport®, incobotulinumtoxin a, Myobloc®, Xeomin®); Enzyme replacement drugs; Erbitux®; Erythropoiesis stimulating agents (ESA), such as darbepoetin alpha, epoetin alpha, epoetin beta and peginesatide; Gattex®; Growth hormone; Hereditary angioedema drugs; Immunologic agents - Actemra®, Amevive, Cimzia®, Enbrel, Humira®, Kineret®, Orencia®, Remicade®, Rituxan®, Simponi®, Stelara® - Xeljanz®, Immunoglobulins; Infertility medications (injectable); Jevtana®, Krystexxa™; Makena™; Multiple sclerosis drugs - Aubagio®, Avonex®, Betaseron®, Copaxone®, Extavia®, Gilenya®, Rebif®, Tecfidera™, Tysabri®; Osteoporosis drugs injectable - Boniva®, Forteo®, Miacalcin® and Prolia®, Zometa®, Reclast® and pamidronate (Aredia®) (for osteoporosis indications only); Pegylated interferon alpha when used for hepatitis C - Pegasys®, PegIntron®, Rebetron®, Roferon A®, Intron A®, Infergen®, Provenge®, Pulmonary arterial hypertension drugs; Soliris®, Synagis®, Vectibix®; Viscosupplementation - Euflexxa®, Gel-One®, HylanG,® Orthovisc®, Supartz®, Synvisc®, Synvisc-One®, Xgeva®, Xolair®, Yervoy™; Zaltrap®

Dental Procedures
- Facility, anesthesia and related medical services for dental care
- Orthognathic and other oral surgery procedures

Durable Medical Equipment (DME) and Prostheses
- Cochlear implants
- CAAP Machines, purchased or rented
- CPM machines for home use
- Canned nutritional
- Cranial molding helmets/bands
- Custom braces
• Diabetic supplies or other supplies exceeding the amount needed for 30 days or as specified in the product benefit
• Limb prostheses
• Wheelchairs/Scooters
• Any other items when the purchase price exceeds $500 regardless of whether the item is being purchased or rented

Genetic/Molecular Testing, except:
• Karyotype/chromosomes, and/or FISH when ordered by a Maternal Fetal Medicine specialist
• Cystic Fibrosis screening (not full sequencing)

Home Health Care including, but not limited to, all nursing services, home infusion therapy and rehabilitative/habilitative services

Hospice

Hyperbaric Therapy

Investigational/Experimental Protocols

Laboratory Testing
• Laboratory testing in an outpatient hospital setting
• Tumor marker testing

Nutritional/Dietetic Counseling

Out-of-Network Services (except emergencies)

Outpatient Procedures/Surgeries
• Balloon sinuplasty
• Biofeedback (all)
• Cardiac devices including implantable defibrillators, defibrillator vests, cardiac resynchronization therapy, and ventricular assist devices
• Circumcision if over one year of age
• Destruction/Removal of benign skin lesion
• GI tract imaging by capsule endoscopy
• Hysterectomy
• Joint lubrication injections such as Synvisc® or Hyalgan®
• Osteochondral allograft or autologous chondrocyte implantation
• Spinal procedures including artificial intervertebral disc replacement, spinal fusion, and vertebroplasty/kyphoplasty
• Temperomandibular joint (TMJ) surgery
• Umbilical hernia surgery if under 5 years of age
• Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures, or other surgeries for obstructive sleep apnea
• Varicose vein procedures

Pain Management Procedures including, but not limited to, external or implanted infusion pumps or stimulator devices, epidural steroid injections, and trigger-point injections.

Pregnancy Services
• All elective inductions
• All elective Cesarean sections
• Terminations/Abortions
• For OBs who are not MFM specialists, authorizations is required for:
  o Use of 17-P
  o Amniocentesis if <35 years of age at EDC
  o More than 2 NSTs or BPP’s (with or without NST) per pregnancy
  o More than 2 ultrasounds per pregnancy

Proton Beam Radiation Therapy

Radiology/Imaging Services (when done in any place of service except inpatient, emergency room, or observation bed status)
• CT Scans, including CT angiography and electron-beam CT scanning (coronary artery imaging) MRA
• MRI
• PET Scan
• Nuclear stress test, SPECT Scans
• Stress echocardiography

Reconstructive/Plastic Surgery/Possible Cosmetic Procedures
• Such as: abdominoplasty, blepharoplasty, breast procedures, craniofacial surgery, liposuction, otoplasty, rhinoplasty, septroplasty, etc.

Rehabilitative/Habilitative Services
• All Physical, Occupational and Speech Therapy (except initial evaluation and re-evaluation)
• All Chiropractic services

Transplantation

Wound Care Services
• Wound care centers
• Wound vacuum devices
• Specialized wound dressings

Authorization Requests

Community accepts the Texas Standard Prior Authorization Request Form for Health Care Services. Submit requests for authorization via the Provider Portal or via fax to 713.295.2283 or 1.844.899.2495. To avoid delays, include supporting documentation and clinical notes to support your request.

Standards for Medical Records

Accessibility and Availability of Medical Records

Community includes provisions in contracts with subcontractors for appropriate access to the medical records of its Members for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, state agencies or any agents thereof.

Record Keeping

Medical records may be on paper or electronic. Community takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

Medical Record Standards

Community sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

• Patient Identification Information: Each page or electronic file in the record contains the patient’s name or patient ID number
• Personal/Biographical Data: Include age, sex, address, employer, home and work telephone numbers, and marital status
• Complete: All entries are dated and author identified
• Legible: The record is legible to someone other than the writer—A second reviewer should evaluate any record judged illegible by one physician reviewer
• 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
• Past Medical History (for patients seen three or more times): Past medical history is easily identified, including serious accidents, operations, and illnesses—For children, past medical history relates to prenatal care and birth
• Immunizations: For pediatric records, there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible
• Diagnostic Information: Includes medication information/instruction to Member
• Identification of Current Problems: Significant illnesses, medical and behavioral health conditions and health maintenance concerns are identified in the medical record
• Education: Member is provided basic teaching/instructions regarding physical and/or behavioral health condition
• Smoking/Alcohol/Substance Abuse: Notation concerning cigarettes and alcohol use and substance abuse is present—Abbreviations and symbols may be appropriate
• Consultations/Referrals/Specialist Reports: Notes from any referrals and consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans
• All emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled
• Hospital Discharge summaries are included as part of the medical record for: 1.) all hospital admissions that occur while the patient is enrolled with Community, and are pertinent to the Member’s current medical condition
• Discharge summaries from prior admissions, as necessary, pertaining to admissions which may have occurred prior to Member being enrolled with Community, and are pertinent to the Member’s current medical condition
• For medical records of adults, the medical record documents whether 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 healthcare relating to the provision of healthcare when the individual is incapacitated
• Documentation: Documentation of evidence and results of medical, preventive and behavioral health screening Documentation of all treatment provided and results of such treatment Documentation of the team members involved in the multidisciplinary team of a Member needing specialty care Documentation in both the physical and behavioral health records of integration of clinical care. Documentation to include:
  o Screening for behavioral health conditions (including those which may be affecting physical healthcare and vice versa) and referral to behavioral health Providers when problems are indicated
  o Screening and referral by behavioral health Providers to Primary Care Providers when appropriate
  o Receipt of behavioral health referrals from physical medicine Providers and the disposition/outcome of those referrals
  o At least quarterly (or more often if clinically indicated) summary of status/progress from the behavioral health Provider to the Primary Care Provider
  o Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder
  o A written release of information which will permit specific information sharing between Providers
• In addition, each Provider’s office must have:
  • A written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use
  • Written procedures for release of information and obtaining consent for treatment

Patient Visit Data
• Documentation of individual encounters must provide adequate evidence of, at a minimum:
  • History and Physical Examination: Appropriate subjective and objective information is obtained for the presenting complaints
  • For Members receiving behavioral health treatment, documentation to include “at-risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social history)
  • Admission or initial assessment includes current support systems or lack of support systems
  • For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased or unchanged during treatment period
  • Plan of Treatment: Includes activities/therapies and goals to be carried out
• **Therapies and Other Prescribed Regimens:** For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate

• **Follow-up:** Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN. Unresolved problems from previous visits are addressed in subsequent visits

• **Diagnostic Tests**

• **Referrals and Results**

• **All other aspects of patient care, including ancillary services**

**Record Review Process**

Community’s record review process assesses the content of medical records for legibility, organization, completion, and conformance to our standards. The record assessment system addresses documentation of the items listed in the Record Keeping.

**Coordination with Department of Family and Protective Services (DFPS)**

Provider must coordinate with Texas 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 to DFPS

• Recognition of abuse and neglect, and appropriate referrals to DFPS

**Provider Marketing Guidelines**

1. Providers are permitted to educate/inform their patients about the CHIP/Medicaid Managed Care Programs in which they participate.

2. Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, Providers must not recommend one MCO over another MCO, offer patients incentives to select one MCO over another MCO or assist the patient in deciding to select a specific MCO.

3. At the patients’ request, Providers may give patients the information necessary to contact a particular MCO or refer the Member to an MCO Member Orientation.

4. Provider must distribute and/or display health-related materials for all contracted MCOs or choose not to distribute and/or display for any contracted MCO:
   a. Health-related posters cannot be larger than 16” x 24”.
   b. Materials may have the MCO’s name, logo, and contact information.

5. Providers are not required to distribute and/or display all health-related materials provided by each MCO with whom they contract. Providers can choose which items to distribute or display from each contracted MCO, as long as they distribute or display one or more items from each contracted MCO that distributes items to the Provider and the Provider does not give the appearance of supporting one MCO over another.

6. Providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5” x 7” and cannot indicate anything more than “MCO is accepted or welcomed here.”

7. Providers may choose whether to display items such as children’s books, coloring books, and pencils provided by each contracted MCO. Providers can choose which items to display as long as they display one or more from each contracted MCO. Items may only be displayed in Common Areas.

8. Providers may distribute Applications to families of uninsured children and assist with completing the Application.

9. Providers may direct patients to enroll in the CHIP and Medicaid Managed Care Programs by calling the HHSC Administrative Services Contractor.

10. Bargains, premiums, or other considerations on prescriptions may not be advertised in any manner in order to
influence a Member’s choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the Program.

Options for Member Non-Compliance
Contact Community Provider Relations in the event that a Member is non-compliant, becomes abusive to you or your staff, and/or continues to demand services that, in your professional judgment, are not medically necessary.

The problem will be researched and resolved. A Primary Care Provider may request (in writing to Community) that a Member be transferred to another primary care physician for the following reasons:

- Member is disruptive, unruly, threatening or uncooperative to the extent that the Member’s behavior seriously impairs the Provider’s ability to provide services to the Member, provided the behavior is not caused by a physical or behavioral health condition
- Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the Provider to treat the underlying medical condition
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary and the Member has received full informed consent regarding the prescribed treatment course
- Primary Care Provider must continue to render services 30 days from the date of the letter mailed to the Member and Community

Remember, physicians are not allowed to withhold or discriminate in any way in the treatment of a Member or to transfer a Member from his/her practice because of the health condition of a Member or the amount of services provided. A Primary Care Provider cannot transfer a Member to another Primary Care Provider without the prior written authorization of the Community Medical Director. Community requests that the physician continue care until Community can successfully transfer the Member to a new Primary Care Provider.

Primary Care Providers shall not refuse to accept a Member as a patient on the basis of health status, previous use of services or the medical condition of the Member.

The Member Education Request Form and Request for Member Reassignment Form can be found at www.CommunityHealthChoice.org.
Dispute Resolution for Providers

There are certain dispute resolution provisions in the Provider contract. For the purposes of clarity, Community incorporates the URAC terminology regarding Administrative and Professional Competence/Conduct disputes. Other types of disputes may include not inviting a Provider to participate in the Community network; immediate termination due to imminent harm and adverse determinations.

Disputes Involving Administrative Matters

Disputes involving administrative matters are those which arise from non-clinical or administrative issues from contracted Providers. The process described herein applies to all contracted Providers, delegated and non-delegated. The contracted Provider under a delegated service (e.g., behavioral health) may also have additional specifically related processes. In compliance with state and federal regulations, URAC standards, and Community internal standards, Community must report to appropriate monitoring agencies, e.g., the Texas Board of Medical Examiners, Health Integrity Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider’s privileges of participation, or denial of acceptance to Community’s Provider network. In the event that Community takes an action to terminate, suspend or limit a Provider’s participation status with Community, Community will provide a dispute resolution process as delineated:

- **Investigation**
  A routine investigation may be initiated by any Senior Manager of Community, the Medical Affairs Department, the CEO, the Medical Director, the Executive Quality Management Committee (EQMC), or the Medical Care Management Committee (MCMC).

- **Results of Investigation**
  The investigation may result in no action or may result in actions up to suspension or termination of participation in the Community Network. In response to such adverse action, the Provider will be mailed a letter with the findings. The letter will advise the Provider of the findings and the Provider’s right to dispute the proposed action and request an appeal hearing. The Provider will be given 30 days to request initiation of an appeal hearing. If the Provider fails to submit a request for an appeal hearing, the appropriate action is taken.

- **Appeal**
  The appeal hearing will include at least three contracted Providers, one of whom must be in the same or similar specialty, if available, to the Provider involved in the dispute and who were not otherwise involved in the earlier action. At the panel hearing, circumstances prompting the consideration of investigation, corrective action or termination are discussed. The requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report with their findings and recommendation for presentation to the EQMC for review and action. If the EQMC’s review of the appeal panel’s findings results in reversing the previous action, the Provider is notified and network privileges are re-instated. If the decision is to uphold the previous action, the Provider will be mailed a letter inclusive of the appeal panel’s findings and action. If the Provider fails or declines to participate in the appeal hearing, the previously action or termination is executed.

- **Reapplication Subsequent to Adverse Action**
  A Provider who has had an adverse action taken against him/her may not reapply for network participation for a period of one year (12 months), unless specified otherwise in the terms of the adverse action.

Disputes Concerning Professional Competence or Conducts

All professional review actions based on reasons related to professional competence or professional conduct that affects or could affect adversely the health or welfare of a patient or patients and that adversely affect a Provider’s privileges for a period of longer than 30 days must be reported, in accordance with Public Law 99-6660 and the Healthcare Quality Improvement Act of 1986. See, 45 CFR 60.9. The process described herein applies to all contracted Providers, delegated and non-delegated. The contracted Provider under a delegated service (e.g., behavioral health) may also have additional specifically related processes.

In compliance with state and federal regulations, URAC standards, and Community internal standards, Community must report to appropriate monitoring agencies, e.g., the Texas Board of Medical Examiners, Health Integrity
Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider’s privileges of participation, or denial of acceptance to Community’s Provider network. In the event that Community takes an action to terminate, suspend or limit a Provider’s participation status with Community, Community will provide a dispute resolution process as delineated:

• **Investigation**  
  A routine investigation may be initiated by any Senior Manager of Community, the Medical Affairs Department, the CEO, the Medical Director or the Medical Care Management Committee (MCMC). The investigation will be conducted by, or under the direction of the Medical Director. The investigative process is not an appeal hearing. An investigation may involve consultation with the Provider, the individual or group making the request, or other individuals who may have knowledge of the events. The Medical Director may also consult with Providers of same or similar specialties of the disputing Provider within the community, including medical schools, Special Investigative Unit (SIU), or same or similar specialists from an independent review company.

• **Results of Investigation**  
  The investigation may result in no action or may result in actions up to suspension or termination of participation in the Community Network. In response to such adverse action, the Provider will be given 30 days to request initiation of an appeal hearing. If the Provider fails to submit a request for an appeal hearing, the adverse action is considered final.

• **Appeal Hearing (Appeals)**
  o **Level 1:** The first-level appeal panel consists of at least three contracted Providers who are not otherwise involved in the day-to-day operations of Community, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier action. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report to the Medical Director and CEO for implementation of their recommendation. If the appeal panel’s findings result in upholding the limitation, suspension, or termination, the Provider will be notified of the appeal panel’s findings and given 10 business days to request a second appeal hearing for reconsideration of the action.
  o **Level 2:** The second-level appeal panel will consist of at least three contracted Providers who are not otherwise involved in the day-to-day operations of Community, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier actions. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report to the Medical Director and CEO for implementation of their recommendation. The Provider will be notified of the second appeal panel’s findings, which are considered final.

• **Reapplication Subsequent to Adverse Action**  
  A Provider who has had an adverse action taken against him/her may not reapply for network participation for a period of one year (12 months), unless specified otherwise in the terms of the adverse action.

**Important Notes**

Regardless of the dispute resolution process described in this policy, automatic and immediate suspension can occur under the following circumstances:

• **Automatic suspension from the member panel shall occur whenever:**
  o A practitioner’s state license or DEA number is revoked, suspended, restricted, or placed under probation;
  o A practitioner fails to satisfy an interview requirement;
  o A practitioner fails to maintain malpractice insurance; and
  o A practitioner’s medical records are not completed in a timely manner.

• **State License Revocation**  
  Whenever a practitioner's license to practice in this state is revoked, his or her panel appointment and practice privileges are immediately and automatically revoked.

• **Restriction**  
  Whenever a practitioner’s license is partially limited or restricted, his or her practice privileges are similarly limited or restricted.
• Suspension/Probation
   Whenever a practitioner’s license is suspended or placed on probation, his or her practice privileges are automatically suspended, effective upon, and for at least the term of, the suspension.

• Drug Enforcement
   Whenever a practitioner’s right to prescribe controlled substances is revoked, restricted, suspended, or placed on probation by a licensing authority (DEA/CDS), his or her privileges to prescribe such substances to MCO enrollees will also be revoked, restricted, suspended, or placed on probation automatically and to the same degree. This will be effective upon, and for at least the term of, the imposed restriction.

• Professional Liability Insurance
   A practitioner who fails to maintain a minimum amount of professional liability insurance will have his or her practice privileges immediately suspended.

• Medical Records Preparation and Completion
   The Member panel policies, rules and regulations outline the requirements for medical record preparation and completion.

• Timely Completion
   A practitioner’s failure to prepare and/or complete medical records within the time period stated in the policy may result in the limitation or automatic suspension of some or all of the practitioner’s privileges.

• Loss of Hospital Privileges
   A practitioner who loses his or her hospital privileges due to incomplete medical records will automatically lose his or her MCO practice privileges for at least the term imposed by the hospital.

• Re-application Subsequent to Corrective Action
   A practitioner who has been denied practice privileges or who has been removed from the Member panel during the appointment year may not reapply for panel appointment or practice privileges for a period of one year (12 months), unless specified otherwise in the terms of the corrective action.
Forms for Providers

These forms can be downloaded at www.CommunityHealthChoice.org > Providers > Medicaid/CHIP > Resources > Forms and Reference Guides.

Member Education Request Form

Request for Member Reassignment Form
## Provider Contact Information Update Form

### Network Provider Update Form (PUF)

**MEDICAID**

**Effective Date:**

**IPA Affiliation:**

**This form may be replaced by an IPA profile with the appropriate information included.**

*Please PRINT all information. If information has changed please mark the box on the right.*

<table>
<thead>
<tr>
<th>PROVIDER'S NEW INFORMATION</th>
</tr>
</thead>
</table>

- **NAME:** First Mi. Last, Degree: [ ]
- **PRACTICE NAME/GROUP:** [ ]
- **PRIMARY SPECIALTY:** [ ]
- **SECONDARY SPECIALTY:** [ ]
- **IPA:** [ ]
- **ADDRESS 1:** [ ]
- **CITY/STATE/ZIP/COUNTY:** [ ]
- **ADDRESS 2:** [ ]
- **CITY/STATE/ZIP/COUNTY:** [ ]
- **PHONE #:** [ ]
- **FAX #:** [ ]
- **AFTER HOURS PHONE #:** [ ]
- **BILLING ADDRESS:** [ ]
- **FEDERAL TAX ID #:** [ ]
- **CITY/STATE/ZIP/COUNTY:** [ ]
- **TPI #(s):** [ ]
- **TEXAS LICENSE #:** [ ]
- **OFFICE MANAGER & CONTACT #:** [ ]

**Please mark the appropriate response.**

- **Type of Practice:** [ ] Group [ ] Solo
- **Accepting New Patients:** [ ] Yes [ ] No If No, estimated date to re-open: ____________
- **Practice Limitations:** Specialty Type Limitation: ____________
- **Office Hours:**

<table>
<thead>
<tr>
<th>MON.</th>
<th>TUES.</th>
<th>WED.</th>
<th>THURS.</th>
<th>FRI.</th>
<th>SAT.</th>
<th>SUN.</th>
</tr>
</thead>
</table>

- **Primary Admitting Hospital(s):** ____________
- **Ethnic Origin:** [ ] White [ ] American Indian/Alaskan
- [ ] Black [ ] Other/Unknown
- **Language(s) Spoken Fluently:** [ ] Spanish [ ] Other(s): ____________
- **Provider Gender:** [ ] Male [ ] Female
- **Public Transit Available:** [ ] Yes [ ] No
- **Handicap Access:** [ ] Yes [ ] No [ ] If Yes, indicate number: ____________
- **THSteps:** [ ] Yes [ ] No If Yes, indicate number: ____________
Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children’s Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization by fax or mail when an issuer requires prior authorization of a health care service. An Issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, through the issuer’s portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient’s condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter “Same.”
- If the requesting provider’s signature is required, you may not use a signature stamp.
- If the issuer’s plan requires the patient to have a primary care provider (PCP), enter the PCP’s name and phone number. If the requesting provider is the patient’s PCP, enter “Same.”

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer’s website before faxing or mailing your request.

Note: If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider’s direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA’s decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.
**Texas Standard Prior Authorization Request Form for Health Care Services**

**Section I — Submission**
- Issuer Name: 
- Phone: 
- Fax: 
- Date: 

**Section II — General Information**
- Review Type: [ ] Non-Urgent  [ ] Urgent  Clinical Reason for Urgency: 
- Request Type: [ ] Initial Request  [ ] Extension/Renewal/Amendment  Prev. Auth. #: 

**Section III — Patient Information**
- Name: 
- Phone: 
- DOB: 
- [ ] Male  [ ] Female  [ ] Other  [ ] Unknown 
- Subscriber Name (if different): 
- Member or Medicaid ID #: 
- Group #: 

**Section IV — Provider Information**
- Requesting Provider or Facility
  - Name: 
  - NPI #: 
  - Specialty: 
  - Phone: 
  - Fax: 
  - Contact Name: 
  - Primary Care Provider Name (see instructions): 
- Service Provider or Facility
  - Name: 
  - NPI #: 
  - Specialty: 
  - Phone: 
  - Fax: 
  - Phone: 
  - Fax: 

**Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)**

<table>
<thead>
<tr>
<th>Planned Service or Procedure</th>
<th>Code</th>
<th>Start Date</th>
<th>End Date</th>
<th>Diagnosis Description (ICD version ___)</th>
<th>Code</th>
</tr>
</thead>
</table>

- [ ] Inpatient  [ ] Outpatient  [ ] Provider Office  [ ] Observation  [ ] Home  [ ] Day Surgery  [ ] Other: 
- [ ] Physical Therapy  [ ] Occupational Therapy  [ ] Speech Therapy  [ ] Cardiac Rehab  [ ] Mental Health/Substance Abuse 
  - Number of Sessions: 
  - Duration: 
  - Frequency: 
  - Other: 
- [ ] Home Health (MD Signed Order Attached? [ ] Yes  [ ] No)  (Nursing Assessment Attached? [ ] Yes  [ ] No)  (Medicaid Only: Title 19 Certification Attached? [ ] Yes  [ ] No) 
  - Number of Visits: 
  - Duration: 
  - Frequency: 
  - Other: 
- [ ] DME (MD Signed Order Attached? [ ] Yes  [ ] No)  (Medicaid Only: Title 19 Certification Attached? [ ] Yes  [ ] No) 
  - Equipment/Supplies (include any HCPCS Codes): 
  - Duration: 

**Section VI — Clinical Documentation (See Instructions Page, Section VI)**

An issuer needing more information may call the requesting provider directly at: 

NOFR001 | 0415  
Page 2 of 2
Specialist Consultant Appointment Form

Community Health Choice (Community) does not require authorization for an in-network specialty provider. Complete form only if you need assistance with a Specialist request.

Date:____/____/____ Time:____:____a.m.____p.m.

Provider Information

Last Name: ____________________________ First Name: ____________________________

Type of Specialist Needed: ____________________________

Does this Member need additional specialty Providers? □ Yes □ No

□ Urgent □ Routine □ Stat

If yes, please complete a separate form.

Office Name: ____________________________ Contact: ____________________________

Phone: ____________________________ Fax: ____________________________ E-mail: ____________________________

Member Information

Last Name: ____________________________ First Name: ____________________________

DOB: ____________________________ Member ID: ____________________________ Language: ____________________________

Need Transportation: □ Yes □ No

Address: ____________________________ City/State: ____________________________ ZIP: ____________________________

Is Member Pregnant? □ Yes □ No

Guardian Name: ____________________________

Clinical Information

Diagnosis: ____________________________ ICD Code: ____________________________

Clinical Notes: ____________________________

~ For Internal Use Only ~

Specialist Information

(Community will complete and return to referring physician.)

Last Name: ____________________________ First Name: ____________________________

Address: ____________________________ City/State: ____________________________ ZIP: ____________________________

Phone: ____________________________ Fax: ____________________________ Specialist Apt. Date/Time: ____________________________

Fax to the Community Specialist Scheduler at 713.295.7050.

Print Form

Community Health Choice

2636 South Loop West, Suite 900 Houston, Texas 77054
Tel: 713.295.2450 • Toll Free: 1.888.760.2500 • Fax: 713.295.7050

fm_specappt_0214 rev. 02/14
Electronic Funds Transfer (EFT) Enrollment Form

This authorization is to remain in effect until Community Health Choice, Inc. has received written notification from me of its termination in such time, and in such manner, as to afford Community Health Choice, Inc. and Financial Institution a reasonable opportunity to act on it.

I agree to applicable Terms and Conditions.

The undersigned person represents and warrants that he/she is authorized to execute this form on behalf of the Provider.

Authorized Signature: Date:

Printed Name: Title:

Print Form

Email to EFT/ERA@CommunityHealthChoice.org or fax to 713.295.7055 - Attention: Provider Database Support

08/2017
Access to Care

Appointment Availability Requirements

Community is committed to ensuring that Members receive timely and appropriate level of access to all levels of care: emergent, urgent, routine, and preventive.

<table>
<thead>
<tr>
<th>Service</th>
<th>Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities</td>
</tr>
<tr>
<td>Urgent</td>
<td>Must be provided within 24 hours, including urgent specialty care and behavioral health services</td>
</tr>
<tr>
<td>Primary Routine Care</td>
<td>Must be provided within 14 days, including behavioral health</td>
</tr>
<tr>
<td>Specialty Routine Care</td>
<td>Must be provided within 21 days</td>
</tr>
<tr>
<td>Routine Care Dental</td>
<td>Within eight weeks for dental</td>
</tr>
<tr>
<td>Initial Outpatient Behavioral Health Visit</td>
<td>Must be provided within 14 days (this requirement does not apply to CHIP Perinatal)</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Initial appointment must be provided within 14 days for non-high-risk pregnancies. For high-risk pregnancies or new members in the 3rd trimester, initial appointment must be provided within 5 days or immediately. Appointments for ongoing care must be available in accordance with the treatment plan as developed by the Provider.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Physical/Wellness Exams</td>
<td>Newborns (less than 6 months of age): Within 14 days</td>
</tr>
<tr>
<td></td>
<td>Children (6 months to 20 years): Within 2 months</td>
</tr>
<tr>
<td></td>
<td>Adults (21 years and older): Within 90 days</td>
</tr>
<tr>
<td></td>
<td>New Members: Within 90 days of enrollment</td>
</tr>
<tr>
<td></td>
<td>*Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule.</td>
</tr>
<tr>
<td></td>
<td>*CHIP Members should receive preventive care in accordance with AAP guidelines</td>
</tr>
</tbody>
</table>

**Emergent/Emergency:** A medical condition that manifests 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 that the absence of immediate medical care could result in one or all of the following:

- Health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) is in serious jeopardy
- Serious impairments to bodily functions
- Serious dysfunction of any bodily organ or part
- Inadequate time to safely transfer a Member who is pregnant and having contractions to another hospital before delivery, or if a hospital transfer might pose a threat to the health or safety of the woman or the unborn child
- Member is a threat to themselves or others; exhibits acute onset of psychosis or severe thought disorganization; risks deterioration from a chronic physical or behavioral health condition that could render the Member unmanageable and unable to cooperate in treatment; or needs assessment and treatment in a safe and therapeutic setting

**Urgent Condition:** A health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that
his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member’s Primary Care Provider or designee to prevent serious deterioration of the Member’s condition or health.

_Routine or Preventive (Non-Emergent)_: Postponement of treatment will not endanger life, limb or mental faculties of patient, i.e., patient’s condition permits adequate time to schedule necessary history and physical, laboratory, radiology or other diagnostic studies on an outpatient basis.

**Primary Care Provider 24-Hour Availability**

Primary Care Providers are required to provide 24-hour availability, seven days a week for Community Members. Arrangements for coverage while off-duty or on vacation are to be made with other participating Providers. Community should be notified of the Provider’s coverage prior to a leave of absence.

Community’s contracts state that Primary Care Providers must “be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, seven days a week.” Additionally, the contracts state that Primary Care Providers must “maintain one of the following to receive calls from Members after normal business hours”:

- Calls may be answered by an answering service which meets the language requirements of the major population groups and can contact the Primary Care Provider or Primary Care Provider designee
- Calls are answered by a recording in the language of each of the major population groups directing the caller to call another number to reach the Primary Care Provider or Primary Care Provider designee. Someone, not another recording, must be available to answer the phone at the number indicated in the message
- Calls may be transferred to another location where someone who is able to contact the Primary Care Provider or the Primary Care Provider designee will answer the phone.
Network Referrals

Network Limitations
Community has an open network. Refer to the Community Web site or the current Community Provider Directory for a list of Primary Care Providers, specialists, OB/GYN physicians and ancillary Providers. Members may go to any in-network Provider (excluding Kelsey-Seybold). Members do not have to be assigned to your panel or change to your panel. Just submit your claim to Community.

Beacon Health Options, the behavioral health management organization supporting Community, also has an open network. Go to the Beacon Health Options Web site at www.BeaconHealthOptions.com for a list of participating behavioral health providers and facilities.

Limited Provider Network (Applies to CHIP only)
Community has a limited Provider network within its service area for the CHIP program. If a CHIP Member selects a PCP in the limited Provider network and needs to select a specialist, the specialty care Provider must be selected and care provided by the limited Provider network specialist. A separate listing of the limited Provider network and alphabetical listing of all the physicians and Providers, including specialists, are available in the limited Provider network. Please refer to the Provider Directory or Community Web site for a listing of participating limited Provider network specialists.

OB/GYN selection is limited to the PCP’s network if the Members select a PCP in a limited Provider network.

Open network access to specialists is restricted to the limited Provider network if there is no PCP referral. If the limited Provider network does not have a Provider for your specialty care, your limited Provider network PCP will refer you to a Provider outside the limited Provider network which will require a referral from PCP.

Members who do not select a PCP in the limited Provider network DO NOT have access to the limited Provider network specialists.

Referral to Ophthalmologist or Optometrist
Members have the right to select and have access to, without Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery.

Network Pharmacy
Members have the right to obtain medication from any network pharmacy. For a list of all participating pharmacies, please visit www.Navitus.com.

Community Members with Special Healthcare Needs
Members with special needs have direct access to a specialist as appropriate for Member's conditions and identified needs. Community does not require prior authorization for in-network specialists.

Referral to Specialists and Health-Related Services
Primary Care Providers should provide a medical home to Community Members. The PCP has the primary responsibility for arranging and coordinating appropriate referrals to other Providers/specialists as well as managing and coordinating the administrative functions related to the delivery of health services in conjunction with Community and case managers as indicated. The PCP or designee may make medically-necessary referrals to specialists for family planning, mental health and emergency services without authorization from Community. A list of these Providers is available online. Authorizations for referrals to in-network specialists are not required.

Primary Care Providers should complete and fax a referral to the specialist and place a copy in the Member’s medical record. The specialist is expected to communicate with the Primary Care Provider regarding services rendered, as well as results, reports and recommendations. This is essential to ensure continuity of care for the Member.

The Primary Care Provider is expected to refer Community Members to contracted behavioral health vendors as needed.
for behavioral health services. If a Primary Care Provider is unsure whether a patient requires behavioral health services, the Primary Care Provider is encouraged to refer the patient to a behavioral health specialist to make that assessment. Also, Community Members may self-refer to behavioral health Providers for treatment. The behavioral health Provider must attempt to obtain a release of information from the Community Member to allow the behavioral health Provider and Primary Care Provider to share this information.

Specialist Scheduling Service

Community offers Specialist Scheduling Service to help Community Providers locate and make appointments with specialists on behalf of Community Members. Our Specialist Schedulers will assist with:

- Locating a specialist
- Locating a nearby hospital
- Schedule the appointment
- Scheduling difficulties
- Updating the Provider and Member
- Benefits inquiries

Web site: www.Communityhealthchoice.org/Providers/ProviderSecure_Default.aspx

Fax: Specialist Consultant Appointment Form to 713.295.7050.

Phone: Specialist Scheduling Service at 713.295.2450 or 1.888.760.2600.

Referral to Network Facilities and Contractors

Providers must comply with all prior authorization and certification requirements and admit patients in need of hospitalization only to network facilities or contracted hospitals unless:

- Certification for admission to an out-of-network facility has been obtained from Community
- The condition is emergent and the use of a network hospital is not practical for medical reasons

To authorize services, please call 713.295.2295, fax 713.295.2284 or submit an authorization online at www.CommunityHealthChoice.org. Behavioral health referrals can be coordinated through Beacon Health Options at 1.877.343.3108.

Out-of-Network Referrals

A Primary Care Provider may request out-of-network referrals for services which cannot be provided within the Community network. Specialists must consult with the Primary Care Provider in a timely manner if out-of-network specialty referrals are needed. Again, specialty referrals include services which cannot be provided within the Community network. To request an out-of-network referral, call Community at 713.295.2295 or submit an Authorization Form on Community’s Web site www.CommunityHealthChoice.org or by FAX to 713.295.2283. Community’s Medical Director will review the clinical information and either authorize or deny the services according to the availability of such services within the Community network, presenting pertinent clinical information and medical necessity. All denials are the responsibility of the Medical Director.

Access to a Second Opinion

Community Members may access a second opinion regarding any healthcare service. A Member must be allowed access to a second opinion from a network Provider or out-of-network Provider, if a network Provider is not available, at no additional cost to the Member.

<table>
<thead>
<tr>
<th>Service</th>
<th>Community Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Requiring immediate intervention and/or medical treatment based on medical necessity</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Referrals</td>
<td>30 days</td>
</tr>
<tr>
<td>Non-High-Risk OB</td>
<td>Within two weeks or less (42 C.F.R. 438.206(b)(3)).</td>
</tr>
</tbody>
</table>
Continuity of Care

Continuity of Care - Pregnant Woman Information
Community will take special care not to disrupt care in progress for newly enrolled Members. Pregnant Members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN Provider through the Member’s postpartum checkup. A Member may change her OB/GYN if she requests.

Continuity of Care - 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.

Our service area includes Brazoria, Fort Bend, Harris, Montgomery, Galveston, Austin, Wharton, Matagorda, Waller, Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler and Walker counties.

Continuity of Care - 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 STAR Member.

Special Access Requirements

Interpreter/Translation Services
Some Community Members will need help communicating with their Providers. While we attempt to assign Members to a Primary Care Provider according to language, history, proximity, etc., it may not always be possible, especially if the Member speaks an unusual foreign language. If you are serving a Community Member who speaks another language, call Member Services at 713.295.2294 or 1.888.760.2600 to access an interpreter. We usually have Spanish interpreters immediately available. Community also has dedicated interpreter Service that has interpreters available for more than 140 languages, 24 hours a day, seven days a week. This service is available by calling Community Member Services Department at 713.295.2294 or 1.888.760.2600. Once a Community Representative has determined an interpreter is needed, he/she will access the Language Line Service by immediately setting up a conference call between themselves, Language Line Services and the Member.

Below are a few guidelines that result in better communication when using an interpreter:

• Keep your sentences short and concise. The longer and more complex your sentences, the less accurate the interpretation. When possible, avoid use of medical terminology that is unlikely to translate well
• Ask key questions several different ways. This increases the chance that you are obtaining a response to exactly what you need to know
• Be sensitive to potential patient embarrassment or reticence. It is possible that your question or statements were not accurately translated or understood
• Ask patients to repeat the instructions you have given. This is a double check on how well they have understood

Providers can communicate with some hearing-impaired Members in writing during office visits. Community can help Providers communicate with the hearing impaired by telephone with a translation device for the deaf. Call Community Member Services TDD/TTY telephone line at 1.800.518.1655 for assistance in any language. Some hearing-impaired Members, especially those who became deaf pre-lingually, may not be able to communicate in writing, but can communicate in sign language. If a Community Member needs a face-to-face interpreter in your office, call Community Member Services at least three business days in advance of the Member’s appointment.
MCO/Provider Coordination

Community will assist the Provider in coordinating the care and establishing linkages, as appropriate for our Members with existing community-based entities and services, including, but not limited to:

- Maternal and Child Health
- Children with Special Healthcare Needs (CSHCN)
- Medically Dependent Children Program (MDCP)
- Community Resource Coordination Groups (CRCGs)
- Texas Department of Assistance and Rehabilitative Services (DARS)
- Home and Community-Based Services (HCS)
- Community Based Alternatives (CBA)
- In-Home Family Support
- Primary Home Care
- Day Activity and Health Services
- Deaf/Blind Multiple Disabled Waiver Program

Community and Providers must ensure that Members with disabilities or chronic or complex conditions have access to treatment by a multidisciplinary team when determined to be medically necessary for effective treatment, or to avoid separate and fragmented evaluations and service plans.

The teams must include both physician and non-physician Providers determined to be necessary by the Member’s PCP for the comprehensive treatment of the Member.

They must:
- Participate in hospital discharge planning
- Participate in pre-admissions hospital planning for non-emergency hospitalizations
- Develop specialty care and support service recommendations to be incorporated into the Primary Care Provider’s plan of care
- Provide information to the Member and the Member’s family concerning the specialty care recommendations

Please contact Community Member Services to assist in coordinating any services that our Members may need such as:
- Transportation to a medically-necessary appointment
- Translation services

Reading/Grade Level Consideration

An estimated 40–44 million Americans are functionally illiterate, and another 50 million are only marginally literate. Nearly half of the functionally illiterate live in poverty. One-fourth report physical, mental or health conditions that prevent them from fully participating in work, school or housework. A study of patients at two public hospitals found that 35 percent of the English speaking and 62 percent of the Spanish-speaking patients had inadequate or marginal functional health literacy, with more than 81 percent of the elderly groups having limited health literacy. Thus, we expect that many of our Community Members have limited ability to understand instructions and read medication bottles. Yet, most people with literacy problems are ashamed and will try to hide them from Providers.

Low literacy can mean that your patient may not be able to comply with your medical advice and prescriptions because they do not understand your instructions.

Member materials should be written at a 4th to 6th grade reading level. The guidelines provided for communication with interpreters are also good guidelines for communicating with Members with limited literacy, especially asking the Member to repeat your instructions. Do not assume that the Member will be able to read instructions or a drawing/diagram for taking prescription medicines. Above all else, be sensitive to the embarrassment the Member may feel about limited literacy.
Community Member Services can assist with interpreters.

**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's interpretive services will help you provide care in a culturally competent manner.

Members requiring behavioral healthcare services should preferably 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, who speaks another language or has specific expertise with a specific culture, they may contact Beacon Health Options 1.877.343.3108 to receive appropriate referrals.

**Non-Emergency Transportation**

When a Community Member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is a non-emergency service. Non-emergency transports for a Community Member with severe disabilities must be to or from a scheduled medical appointment.

A round-trip transfer from the Member’s home to an outpatient or freestanding dialysis or radiation facility is covered only when the Member meets the definition of severely disabled.

“Severely disabled” means that the Member’s physical condition limits his/her mobility and requires the Member to be bed-confined at all times, unable to sit unassisted at all times or requires continuous life-support systems, including oxygen or IV infusion. A run sheet or other supporting documentation is required for non-emergency transportation and must clearly state the Member’s physical condition and severity at the time of the transfer. The run sheet must include the signature of the EMT transporting the client. Non-emergency transfers of a Member's whose condition does not meet the severely disabled criteria are not covered benefits.

**Medical Transportation Program (MTP) – STAR only**

Medical Transportation Program (MTP) is a state run program to ensure that Medicaid members have transportation to and from facilities for their appointments when no other transportation is available. See the STAR section of this provider manual for more information on MTP.

**Transportation Value-Added Services**

Community offers free transportation for Medicaid Members to doctors’ appointments when State Medical Transportation is not available and when approved by Community’s case manager. Community also offers free transportation for CHIP Members to doctors’ appointments if no other transportation is available. The Member must call Community for approval at least three business days before the Member’s appointment.
Emergency Services

Emergency Room Services

Emergency room Providers are authorized by Community to provide medically necessary and appropriate treatment for any Community Member. If a Community Member needs to be admitted, the hospital must notify the Community Utilization Management Department within 24 hours of the admission or the next business day, by either calling 713.295.2295 or 1.888.760.2600, by faxing the encounter record to 713.295.2284 or on our Web site at www.CommunityHealthChoice.org. The Primary Care Provider should also be notified by the hospital about the admission within 24 hours or the next business day.

Whenever a Community Member presents to an emergency room with a non-emergent condition, the Member must be assessed and their Primary Care Provider must be contacted (the name of the Primary Care Provider is located on the Member ID card) for appropriate treatment or education.

If the Primary Care Provider or on-call Provider cannot be reached, the hospital should:

- Document attempts to contact the Primary Care Provider
- Treat the Member

Notify the Primary Care Provider of services rendered by faxing a copy of the encounter to Community at 713.295.2284. Community will forward a copy to the Primary Care Provider within 24 hours or the next business day. Follow-up care should be referred to the Primary Care Provider.

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 submit the following information:

- “Prior Authorization type Code” (Field 461-EU) = ‘8’
- “Prior Authorization Number Submitted” (Field 462-EV) = ‘801’
- “Days’ Supply” in the claim segment of the billing transaction (Field 405-D5) = ‘3’

Call 1.877.908.6023 for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation

The ambulance transport is an emergency service when the condition of the client is life threatening and requires use of special equipment, life-support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could 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 transport must document the aforementioned criteria.
Emergency Dental Services

Medicaid Emergency Dental Services
Community is responsible for emergency dental services provided to Medicaid 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; and
- treatment of oral abscess of tooth or gum origin

CHIP Emergency Dental Services
Community is responsible for emergency dental services provided to CHIP Members 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; and
- treatment of oral abscess of tooth or gum origin
Behavioral Health

Behavioral health services are covered services for the treatment of mental health and emotional disorders as well as substance abuse disorders as defined by the DSM V and/or ICD-10 classification systems. Those services include treatment at inpatient, outpatient, and divisionary levels of care.

An emergency behavioral health condition is any condition, without regard to the nature or cause of the condition, which requires immediate intervention or medical attention. Without this emergency behavioral health treatment or intervention, Members might present an immediate danger to themselves or others, or Members may be incapable of controlling, knowing or understanding the consequences of their actions.

Medically necessary behavioral health services are:

• Reasonable and necessary to diagnose and treat a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
• In accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare
• Provided in the safest, most appropriate and least restrictive setting
• Not omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered

Behavioral Health Provider Access Standards

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent/Life Threatening</td>
<td>Immediate</td>
</tr>
<tr>
<td>Emergent/Non-life Threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 10 Business Days</td>
</tr>
</tbody>
</table>

Primary Care Provider Requirements for Behavioral Health

Community Primary Care Providers must screen, evaluate, refer and/or treat any behavioral health problems and disorders. The Primary Care Provider may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues.

Beacon Health Options’ toll-free number is answered 24 hours a day, seven days a week by qualified mental health professionals who will assist you in identifying an appropriate contracted behavioral health Provider for your patient. (The Provider is responsible for maintaining treatment records and obtaining a written medical record release from the Member or a parent/legal guardian of the Member before records can be released.)

Self-Referral

Community Members may self-refer to any in-network behavioral health Provider. Please contact Beacon Health Options for additional information. Community provides information to Members regarding how and where to obtain behavioral health services.

Behavioral Health Services and Value-Added Services

Community has selected Beacon Health Options as our behavioral health services Provider for the treatment of mental health and drug and alcohol abuse issues. Available behavioral health services include:

• Psychiatric assessment and referral services
• Individual, family and group counseling
• Acute inpatient hospitalization
• Short-term residential
• Partial hospitalization for mental health conditions (value-added benefit)
• Intensive outpatient programs (value-added benefit)
• Medication evaluation and monitoring
• Referral for other community services
• Case management
• Attention Deficit Hyperactivity Disorder (ADHD) services
• Off-site service (home-based, school-based, mobile crisis, home health) (value-added benefit)
• Forensic services (value-added benefit)

Coordination Between Behavioral Health and Physical Health Services

Behavioral Health Providers should report back to the Primary Care Provider their findings, recommendations and treatments for coordination between behavioral health and physical health services.

Medical Records Documentation

Community contracted behavioral health vendor Providers must use the current version of the DSM. This information, as well as assessment/outcome information, is to be documented in the Member’s treatment record.

Consent for Disclosure of Information

Information concerning the diagnosis, evaluation or treatment of a Community Member by a person licensed or certified to perform the diagnosis, evaluation or treatment of any medical, mental or emotional disorder, or drug abuse, is normally confidential information which the Provider may disclose only to authorized persons. Family planning information is particularly sensitive and confidentiality must be assured for all clients, especially minors. Client information may only be released after the client provides a written release of information.

Court-Ordered Commitments

Inpatient psychiatric services must be provided to Community Members, under the age of 21, who have been ordered to receive the services by a court of competent jurisdiction or as a condition of probation under the provisions of Chapters 573 and 574 of the TX Health and Safety Code, relating to court-ordered commitments to psychiatric facilities. Community/Beacon Health Options cannot deny, reduce or controvert the medical necessity of any of these court ordered inpatient psychiatric services, nor can the Member appeal these court ordered commitments through Community’s/Beacon Health Options’ complaint or appeals process.

Coordination with Local Mental Health Authority (LMHA)

The LMHA functions to perform assessments to determine eligibility for rehabilitative and targeted MHMR case management services. Providers of outpatient behavioral health services who believe their Community/contracted behavioral health vendor Member qualifies for targeted case management or rehabilitation services through the LMHA may refer to the LMHA office nearest to the Member. The Member will be assessed to determine if he/she meets criteria for Severe and Persistent Mental Illness (SPMI) or Severe Emotional Disturbance (SED).

Providers can locate the local mental health authority by contacting the Texas Department of State Health Services at 1.800.252.8154 or at http://www.dshs.state.tx.us/mhservices/.

Beacon Health Options actively coordinates behavioral health care with the local LMHA’s within the specific services areas, including Harris County MHMRA, Gulf Coast Center MHMR, Tri-County Services MHMR, Spindletop MHMR, and Burke Center MHMR.

Assessment Instruments for Behavioral Health: Beacon Health Options PCP Toolkit

Beacon Health Options developed a comprehensive PCP Toolkit for Primary Care Providers, 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. Delivering behavioral health services in a primary care setting can help reduce the stigma associated with mental health diagnoses. Primary care
settings are also becoming the first line of identification for behavioral health issues, and Primary Care Providers are the center of care for many patients who have both physical and behavioral health disorders. To support Primary Care Providers, this online toolkit will assist in identifying behavioral health conditions through well-known screening tools, as well as decision support. Condition-specific fact sheets, as well as other patient-centered information, are included in the toolkit so Primary Care Providers can help their patients understand their diagnoses and take the right steps to become and stay healthy.

Conditions included in the toolkit:

- ADHD (Adult ADHD Assessment Tool, ADHD Rating Scale for Child ADHD, NICHQ Vanderbilt Assessment)
- Alcohol/Substance Abuse (Screening for Co-Occurring Mental Health and Substance Abuse Disorders, CRAFFT Provider, National Institute on Alcohol Abuse and Alcoholism)
- Anxiety (Generalized Anxiety Disorder 7-item Scale)
- Depression (PCP Depression Assessment, PHQ-9 Questions)
- Adolescent Depression (Adolescent PHQ-9)
- Postpartum Depression (Edinburgh Postnatal Depression Scale)
- Eating Disorders (SCOFF Questions)
- OCD (OCD Screening Test, OCD Screening Tool)
- PTSD (PTSD Checklist-Civilian Version, VA/DOD PTSD Provider Tool, PTSD Symptom Scale Interview, Primary Care PTSD Screening Tool)
- Schizophrenia (Member Materials)

Providers may access the PCP Toolkit online at pcptoolkit.beaconhealthoptions.com.

**Major Depression Indicators**

- Diagnosis is supported by a minimum of five symptoms documented in the medical record per the current Diagnostic and Statistical Manual of Mental Disorders (DSM V)
- Patient is treated in appropriate setting based on Beacon Health Options Level of Care Guidelines
- During initial assessment, the following are assessed:
  - Suicide risk
  - History and physical, and/or the initial assessment documents for co-existing medical problems (i.e., dementia, epilepsy, HTN, cardiac disease) and substance abuse history
  - Current medications including over-the-counter and prescribed psycho-tropics. Beacon Health Options can assist with referral to behavioral health treatment providers in the member’s home area as appropriate
- Medical record shows improvement with medication and psychotherapy within six to eight weeks. If not, medical record shows that medication was changed or other psychotherapy added
- Improvement in symptoms is documented during the hospital stay. If not, outpatient sessions or alternatives are considered
- If diagnosed with psychotic depression, a combination of psychotherapy, anti-depressant and anti-psychotic medication is utilized or there is documentation as to why not
- ECT can be considered in the event that psychiatric medication management provided over an appropriate time period has not provided stabilization or improvement, or consistent with some co-existing medical conditions
- Evidence that patient has follow-up with a therapist or physician within seven days of discharge from inpatient facility/program

**Substance Abuse Indicators**

- Diagnosis is supported by symptoms documented in the medical record per DSM V,
• Patient is treated in appropriate setting based on Level of Care Guidelines

• During initial assessment, the following is assessed:

  - Suicide risk
  - Severity of withdrawal symptoms (past and present)
  - Most recent amount of substance used
  - Time lapsed since last use
  - Frequency and duration of use
  - Routes of administration
  - How patient feels drugs/alcohol affects him/her (including alcohol and any other drugs)
  - Complete psychiatric history
  - Substance use history
  - Treatment history

  - Family history
  - Social issues
  - Psychiatric or medical illness as etiology of symptoms
  - Vocational issues
  - Medical evaluation
  - Relationship issues
  - Motivation for treatment (Why now?)
  - Financial status
  - Current prescription and OTC medications
  - Legal status

• The patient is referred (or not) for psychiatric evaluation when symptoms, history and/or testing indicates the need

• Improvement in symptoms is noted during subsequent sessions or days in hospital or documentation for reasons for lack of improvement and alternatives considered

• If diagnosed with withdrawal syndrome, appropriate application of detoxification guidelines is documented or documentation of reasons not using guidelines

• If there is a lack of progress, other levels of care, modes of treatment and/or other professionals are considered for consultation

• Written plan for relapse prevention including high-risk periods

• Documentation of use of long-term (beyond seven-day detox) medications and response (if applicable, i.e., Methadone)

• Documentation of continued evaluation for suicide

• Referral to appropriate aftercare for long-term monitoring

Inpatient Discharge Follow-Up and Missed Appointment Procedures

Community Members receiving inpatient psychiatric services must be scheduled for outpatient treatment prior to discharge and must receive outpatient treatment within seven days from the date of discharge. Behavioral health aftercare services can be provided by psychiatrists, psychologists, licensed therapists or alternative care services, as appropriate for the individual member. Missed appointments should be rescheduled within 24 hours.

Physical Health Lab/Ancillary Tests

Behavioral health Providers are required to refer Members with physical health problems to their Primary Care Provider for treatment.

Providers should utilize participating laboratory vendors to provide analysis of labs related to outpatient psychiatric medication management. Members can go to any Medicaid-eligible lab for lab services.

Behavioral Health Focus Studies and Utilization Management Reporting Requirements

Community and Beacon Health Options are contractually required to inform and include all Providers in health plan quality reporting and activities. Behavioral health Providers are required to participate in the following UM/QI Plan:

• UM Reports: Based on modified HEDIS measures (performed on 100 percent of submitted claims/encounters) the data is obtained through medical records data and Provider and Member surveys

• Member Records: Randomly selected for auditing
• Encounter/Claims Data: Submitted on CMS 1500 or UB 04 format. It is critical that these claims be filed clearly and correctly
• Provider Surveys: Please complete and return
• Member Surveys: Random number of Members selected to complete
• Provider Profiles: Community will complete and make available to the Provider

Dental Services

Role of Main Dental Home

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

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

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists 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 5 business days.

If a Member does not have a dental plan assigned or is missing a card for a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker’s toll-free telephone number at 1.800.964.2777.

Non-Emergency Dental Services

Medicaid Non-Emergency Dental Services

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

Community is responsible for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

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

• OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
• OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
• Documentation must include all components of the OEFV.
• Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member’s Main Dental Home choice in the Members’ file.

CHIP Non-Emergency Dental Services

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

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

*See Emergency Services section in this manual for information on Emergency Dental Services.

Pharmacy

Pharmacy benefits for Community members are administered by Navitus Health Solutions, a pharmacy benefit management company. For questions related to pharmacy benefits, including participating pharmacies, formulary, preferred drugs, billing, prescription overrides, prior authorizations, quantity limits, or formulary exceptions, please call Navitus Customer Care toll-free at 1.877.908.6023 or visit www.Navitus.com. The Navitus formulary adheres to the VDP formulary or preferred drug list and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called the Pharmacy and Therapeutics (P&T) Committee. The formulary includes two tiers of coverage:

- Tier 1 – Mostly generic drugs
- Tier 2 – Typically formulary brand name drugs

Role of Pharmacy

Community makes payment for medically necessary prescriptions of covered outpatient drugs to pharmacy providers contracted with Navitus. Medicaid members may receive medically necessary prescriptions from the Medicaid enrolled pharmacy of their choice. Navitus negotiates drug costs with manufacturers and contracts with most pharmacies.

A complete list of participating pharmacies is available on the Navitus Web site at www.Navitus.com or by calling Navitus customer care 1.877.908.6023.

Pharmacy Provider Responsibilities

Pharmacy Providers participating in the Texas Medicaid Program or CHIP Programs must comply and adhere to the Formulary and Preferred Drug List (PDL). Pharmacy Provider will fill prescriptions according to the Prescriber’s directions and coordinate with the prescribing physician to assure the authenticity of the prescription drug order. Pharmacy Provider will ensure Members receive all medications for which they are eligible by ensuring reasonable verification of the identity of the patient, prescriber and if appropriate, caregiver. Pharmacy Provider must provide coordination of benefits when a Member also received Medicare Part D services or other insurance benefits.

How to Find a List of Covered Drugs

The Navitus formulary adheres to the VDP formulary or preferred drug list and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called the Pharmacy and Therapeutics (P&T) Committee. Drugs eligible for reimbursement are listed in the current Texas Listing of National Drug Codes. The formulary is available at www.Navitus.com/texas-medicaid-star-chip/formulary.aspx.

How to Find a List of Preferred Drugs

Providers can find a list of preferred drugs at www.Navitus.com.

How to Find a List of PA Required Services and Codes

Some medications do require prior authorization. More information is available at www.Navitus.com. On the formulary, medications that require prior authorization for coverage are marked with “PA.” A response of “PA Not Required” on a returned request form is not a guarantee of payment. The services must be a benefit of the member’s enrollment in order to be considered for payment. “PA Not Required” does not mean that service is covered.
Process for Requesting Prior Authorization

Physicians submit the prior authorization requests for any medications marked with “PA.” Navitus will review the PA request immediately if by telephone and within 24 hours if by fax or Web site.

Navitus processes Texas Medicaid pharmacy PAs for Community. The formulary, PA criteria, and the length of the PA approval are determined by HHSC. Information regarding the formulary and the specific PA criteria can be found at the vendor drug Web site, ePocrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms at https://www.navitus.com under the “Providers” section or have them faxed by Customer Care to the prescriber’s office. Prescribers will need their NPI and State number to access the portal. Completed forms can be faxed 24 hours a day, seven days a week to Navitus at 920.735.5312.

Prescribers can also call Navitus Customer Care at 877.908.6023 to submit a PA request over the phone. Choose the “Prescriber” option, and speak with the Prior Authorization department between 8:00 a.m. – 5:00 p.m., Mon. – Fri. (CST). After hours, Providers may leave a voicemail. Decisions regarding PA will be made within 24 hours from the time Navitus receives the PA request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require PA will undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires PA. At that point, the pharmacy should notify the prescriber, and the above process should be followed. Additional details including pharmacy billing instructions are located in the Navitus Pharmacy Provider Manual on the Navitus Web site at www.Navitus.com. For questions regarding Navitus, call 1.877.908.6023 or visit the Navitus website at www.Navitus.com.

When a PA is required, and the Provider is not available to submit the PA request, HHSC requires pharmacies to dispense a 72-hour supply as long as the Member will not be harmed. The 72-hour emergency fill is for any Medicaid STAR recipient. If the prescribing Provider cannot be reached, or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. This also applies if a PA request was submitted but Navitus could not make a decision within 24 hours of receipt. This procedure should not be used for routine and continuous overrides but can be used more than once if the Provider remains unavailable.

Durable Medical Equipment and Other Products Normally Found in A Pharmacy (STAR)

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must enroll with Community by contacting Navitus at 1.877.908.6023. Pharmacy claims should be submitted to Navitus.

Call Navitus at 1.877.908.6023 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).
Disease Management and Complex Case Management

Care Management/Disease Management Program

Primary Care Providers are expected to transmit information to the Community Disease Management Department for those Community Members who elect to participate in one of Community’s Disease Management programs. Requested information will vary with each disease; however, may include, but not be limited to, the following:

- Laboratory information
- General medical records
- Pharmacologic information
- Referral notifications
- Special needs to be addressed, if any
- Demographic information

It is vital to the success of the program that the Primary Care Provider informs the Member about the program and that you are referring them. Physician support is key. Community does not require that a specific referral form be filled out to refer a Member to our Care Management/Disease Management Programs. Please indicate to which program you would like to refer the Member (i.e. diabetes, asthma, high risk perinatal, congestive heart failure). Include any pertinent clinical information (i.e. asthma action plan, A1c, recent notes, or plan of care). Community always wants to support the plan of care or instructions provided by the physician. Once a care plan is developed with the Primary Care Provider, the care plan will be mailed to both the enrolled Member and the Medical Home Physicians. Follow-ups to the care plan will be forwarded on a routine basis to the Medical Home Physician.

Care Management/Disease Management at Community

Community defines disease management as a system of coordinated healthcare interventions and communications for populations with the disease states in which Member self-care efforts are significant. A critical objective of the Disease Management program is to enhance the Member’s ability to self-manage the disease through the application of prevention skills, self-monitoring, avoidance of risk behaviors, and informed decision making related to healthcare resources.

Care Management/Disease Management and Community Providers

Community employs a Member-centric approach to developing the most effective and successful partnerships with our Members and Providers. We count on our Primary Care Providers and specialists to provide an invaluable feedback loop that ensures the success of our programs. Our goal is to complement rather than complicate our Providers who are treating Members in the Disease Management programs. Community makes available an integrated staff support team from various clinical and managed care disciplines to coordinate with the assigned Primary Care Providers and other medical Providers participating in the Member's care and help the Member achieve positive health outcomes. Through Disease Management programs, Community works with Members, their healthcare Providers, and families to assist the Member in reaching and maintaining an optimal health status that avoids costly and unnecessary services.

There are many reasons to refer Members to the Disease Management program:

- Education specific to disease via quarterly updates
- Open access to network specialists and assistance with appointments
- Coordination of ancillary services
- Individualized plan of care
- Telephonic case management
- Transportation assistance
- 24-hour Help Line for Members
- Referrals to our Community Health Workers for home visits and assistance with community resources
- Programs are at no cost to the Member and they can elect to withdraw at any time
Program Description Criteria

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Risk Perinatal</td>
<td>Targeted to moms-to-be who are high risk and can benefit from education and support</td>
<td>High risk, history of pre-term births, multiple pregnancies or other complications</td>
</tr>
<tr>
<td>Asthma</td>
<td>Targeted interventions for adolescents and children with asthma</td>
<td>Under 19 years of age</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Targeted interventions for Members with Type I and Type II Diabetes</td>
<td>No age limit</td>
</tr>
</tbody>
</table>

Contact our Care Management/Disease Management department at 832.CHC.CARE (832.242.2273) or 1.888.760.2600. Referrals may be faxed to 713.295.7028 or e-mail to CMCoordinators@CommunityHealthChoice.org.

**Complex Case Management Program**

Primary Care Providers are expected to transmit information to the Community Complex Case Management Department for those Community Members who elect to participate in one of Community’s Complex Case Management programs. Requested information will vary with each disease; however, may include, but not be limited to, the following:

- Laboratory information
- Pharmacologic information
- General medical records
- Referral notifications

Once a care plan is developed with the Primary Care Provider, the care plan will be mailed to both the enrolled Member and the Medical Home Physician. Follow-ups to the care plan will be forwarded on a routine basis to the Medical Home Physician.

**Complex Case Management at Community**

Community defines complex case management as a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

**Complex Case Management and Community Providers**

Community employs a Member-centric approach to developing the most effective and successful partnerships with our Members and Providers. We count on our Primary Care Providers and specialists to provide an invaluable feedback loop that ensures the success of our programs. Our goal is to complement rather than complicate our Providers who are treating Members in the Complex Case Management programs. Community makes available an integrated staff support team from various clinical and managed care disciplines to coordinate with the assigned Primary Care Providers and other medical Providers participating in the Member’s care and help the Member achieve positive health outcomes. Through Complex Case Management programs, Community works with Members, their healthcare Providers, and families to assist the Member in reaching and maintaining an optimal health status that avoids costly and unnecessary services.

There are many reasons to refer Members to the Complex Case Management program:

- Support member’s adherence to care plans to improve health complexities
- Advocacy to ensure appropriate services and resources are received
- Education and promotion of self-management in order to empower members to take an active role in their health care
- Coordinated and seamless integration of complex services and/or special needs
- Referrals to appropriate medical, behavioral, social and community resources
- Telephonic case management
- 24-hour Help Line for Members
Quality Management

Clinical Practice Guidelines

As part of its quality improvement process, Community and Beacon Health Options develops standards and practices guidelines in accordance with:

- Preventive care and acute and chronic care standards utilizing national standards as appropriate to the condition as designated by the Texas Health and Human Services Commission (HHSC)
- Periodic pediatric health screenings based on the Texas Health Steps (THSteps) and the American Academy of Pediatrics (AAP) standards
- Immunization guidelines based on the Advisory Committee on Immunization Practices
- Prenatal care standards based on the minimum standards of the American College of Obstetricians and Gynecologists (ACOG)

Community consults with network healthcare Providers through the Medical Care Management Committee regarding clinical practice guidelines and policies and procedures related to the quality of clinical care delivered to Community enrollees. Community reviews clinical practice guidelines annually and updates them as needed. Community disseminates the guidelines upon request to the Provider network and Members. Guidelines are located on Community web site and included in provider newsletters.

Quality Improvement Program

The Quality Improvement Program is a comprehensive framework for continuous assessment and improvement of clinical and non-clinical processes and outcomes, by identifying areas of opportunity and implementing new approaches to identify and resolve causes of systematic problems or barriers to improvement. The Quality Improvement Program is evaluated annually and amended, as needed. Review of the program is conducted by the Executive Quality and Compliance Committee (EQCC). The plan is reviewed by the Medical Care Management Committee (MCMC) and submitted to the Board of Directors for approval.

Quality Improvement Principles

- Community has adopted the Institute for Healthcare Improvement’s Triple Aim approach to optimizing health system performance. Community’s goal is to improve health outcomes for individuals and populations while improving their experience of care and, at the same time, reducing per-capita costs.
- Maintain a quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes.
- Focus on improved Member health outcomes that involve both process outcomes and health outcomes.
- Foster teamwork environment where each employee is a contributor to the improvement of processes and outcomes.
- Use the Plan-Do-Check-Act (PDCA) model to evaluate the effectiveness of all quality improvement initiatives.

Quality Improvement Program Focus Areas

- Health care access
- Health care delivery
- Contracting and contract administration
- Provider credentialing
- Peer review
• Customer service and satisfaction
• Provider service and satisfaction
• Risk minimization
• Utilization management and complex case management
• Care (Disease) management
• Preventive and interventional healthcare services
• Delegation oversight and compliance

Quality Improvement Studies

The purpose of healthcare Performance Improvement Projects (PIP) is to assess and improve processes and thereby outcomes of care. In order for such projects to achieve real improvements in care and for Community, Providers and Members to have confidence in the reported improvements, PIP must be designed, conducted and reported in a methodologically sound manner. Annually and periodically throughout the year, the Medical Care Management Committee, Medical Directors, and associate staff review and evaluate PIP purpose, design and methodology. Findings and recommendations from the PIP are to be communicated to the Provider network as warranted through faxes, newsletters and the Web site. Data and information specific to the PIP findings may also be communicated through the Medical Director or nurse reviewer during scheduled office visits. Currently, Community conducts the following quality improvement activities:

• Improve access to aftercare – Improve 7 and 30-day ambulatory follow-up post hospitalization for mental illness
• Decrease incidents of Potentially Preventable Admissions for Asthma
• Improve access and increase utilization for outpatient services to reduce Potentially Preventable ED Visits for members with Upper Respiratory Tract Infections
• Improve rates of timeliness of prenatal care, postpartum care, and frequency of prenatal care
• Improve rates of weight assessment and counseling for nutrition and physical activity

Utilization Management Reporting Requirements

Community is contractually required to inform and include all Providers in health plan quality reporting and activities. Providers are required to participate in the following UM/QI Plan:

• UM Reports: Based on modified HEDIS measures (performed on 100 percent of submitted claims/encounters) the data is obtained through medical records data and Provider and Member surveys
• Member Records: Randomly selected for auditing
• Encounter/Claims Data: Submitted on CMS 1500 or UB 04 format. It is critical that these claims be filed clearly and correctly
• Provider Surveys: Please complete and return
• Member Surveys: Random number of Members selected to complete
• Provider Profiles: Community will complete and make available to the Provider
Billing and Claims

Forms to Use
Claims and/or encounter data must be submitted on the current standard CMS 1500 Form or UB-04.

Required Information for CMS 1500 Claims
All claims/encounter data should include the following:

- Patient name
- Patient date of birth
- Member’s CHIP or Medicaid ID number
- Insured’s name
- Patient’s relationship to insured
- Information on any other coverage applicable to the patient
- If any other insurance on patient, need policy and/or group number
- Insurance plan name
- Date of illness, etc. (Maternity claims must include the LMP date)
- Claims for treatment of an injury must include injury date
- Referring physician’s name, if applicable
- ICD-9/10 diagnosis codes
- Provider’s Tax ID number
- Provider’s NPI number
- THSteps claims must include TPI number
- Date of services
- Place and type of service codes
- CPT-4 or HCPCS procedure codes with modifiers where appropriate
- Diagnosis code by specific service
- Tax ID number of the physician for the service
- Total charge
- Signature of treating physician for the services
- Name and address of facility where services rendered (other than home or office)
- Billing name and address of physician performing the service

When submitting a claim, please follow the guidelines below:

- A separate claim must be completed for each Member and each Provider.
- Please allow 45 days for claims processing prior to submitting a duplicate claim.

When submitting a replacement claim, please follow the guidelines below:

- If your claim is denied because it did not contain critical claims elements that are required for adjudication of clean claims, or you did not submit as indicated above, you may submit your corrected electronic or paper claim with the resubmission code 7 in box 22 of the CMS-1500 claim form or in Loop 2300 electronically. You must indicate the original claim number in the Original Reference number field along with the resubmission code. Print “CORRECTED CLAIM” if submitting paper claim.
- This is NOT an appeal. Do not send corrected claims to the Appeals Department. All corrected claims should respond to the error messages as delineated on the EOB. Claims adjudication status is available 30 days after the submission of a clean claim, by mail or 24 hours a day on the Community Web site at https://www.CommunityHealthChoice.org.
- Community follows TMHP billing standards for STAR. Community follows TDI Clean Claims guidelines for CHIP. If any special billing requirements are necessary (e.g. newborns, value-added services, SSI, compounded medications, etc.), Community will inform the Provider.
Required Information for UB-92/UB 04 Claim Forms

- Name and address of facility providing the service
- Patient's name and address
- Patient control number (patient account number)
- Patient's DOB, sex, MS
- Bill type
- Medical Record Number
- Tax ID number of the facility providing the service
- Admission date and admit hour, and discharge hour
- NPI Number
- Discharge status
- Coverage period
- Value codes
- Description of service
- Three-digit revenue code
- HCPCS codes (outpatient claims)
- Insured’s name
- Individual service dates (outpatient claims)
- Patient’s plan ID number
- Number of units
- Authorization number
- Billed charges for each revenue code
- ICD-10 diagnostic codes
- Total charges
- DRG code, if applicable
- Payer
- Surgical procedure codes

If billing for outpatient surgery revenue codes, please include the corresponding CPT-4 code. The CPT-4 code must be specific; unlisted procedure codes are not acceptable. Claims submitted for outpatient surgery without the CPT-4 code will be denied.

Monthly Capitation Services

Primary Care Providers who meet certain qualifications may qualify for capitation in addition to fee-for-service billing. Refer to your provider contract or call Community Provider Relations at 713.295.2295 for more information.

Reimbursement Methodology

Community reimburses certain Providers based on the Texas Medicaid Fee Schedule. These rates are set by the State Medicaid Program and are available at http://www.tmhp.com. In accordance with the rules of reimbursement of the Texas Medicaid Program, when a Provider is paid under this type of reimbursement methodology, the Provider is paid the lower of its billed charges or the published Medicaid rate.

Beacon Health Options reimburses certain Providers based on the Beacon Health Options Texas Medicaid and CHIP Fee Schedule. Obtain a copy of this fee schedule by contacting the Beacon Health Options Provider Operations Department. When a Provider is reimbursed under such a methodology, the Provider is paid the lower of its billed charges or the established contractual rate.

For facilities that bill using Diagnosis Related Groups (DRGs), Community pays as billed. Claims are adjudicated based on the authorization that was completed. Facilities must bill their claims with the Present of Admission (POA) identifier or claims will be denied.

Beacon Health Options does not currently utilize DRG reimbursement methodology for behavioral health facility charges. Beacon Health Options utilizes a per diem methodology inclusive or exclusive of physician fees, dependent upon the specific contractual provisions with the facility.

Emergency Services Claims

An emergency is defined as any condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a lay person possessing an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical care could result in:

- Placing the patient’s health in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child)
• Causing serious impairment to bodily functions
• Causing serious dysfunction to any bodily organ or part
• Serious disfigurement

No authorization is required for hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition, as well as services by emergency professional/physicians. This includes a medical screening to evaluate care levels and stabilization services needed to admit or release patient. Authorization is required for post-stabilization services. Emergency service claims are required to follow all claims billing procedures. Claims must identify emergency services with service code 450 or place of service 23.

**Time Limit for Submission of Claims/Claims Appeals**

All claims must be submitted within 95 days from the date of service. Claims not filed within 95 days from the date of service may not be considered for reimbursement. All encounter data must be submitted within 30 days from the date in which the encounter for service occurred. Appeals must be submitted within 120 days from date of last disposition.

**Clean Claims Payment**

A clean claim is defined as a claim submitted by a physician or provider for health care services rendered to a member, with all data necessary for the health plan to adjudicate and accurately report the claims. Claims must be submitted using the current standard CMS 1500 Form or UB-04.

All “clean” claims will be adjudicated within 30 days of receipt. A Provider will be notified in writing, if additional information is needed to process claim. If a “clean” claim is not adjudicated within 30 days of receipt, Community is responsible for paying Providers interest at a rate of 1.5 percent per month (18 percent annually) for each month the claim continues to go unadjudicated. Pharmacy “clean” claims will be adjudicated within 18 days for electronic pharmacy claim submission. Non-electronic pharmacy claims will be adjudicated within 21 days of submission.

Claims submitted by Providers who are under investigation or have been excluded or suspended from state programs for fraud and abuse will not be considered for payment.

**Out-of-Network Provider Payments**

Community will be responsible for out-of-network claims for Members with care in progress with nonparticipating Providers until Member’s records, clinical information and care can be transferred to a network Provider. Payment shall be within the time limits set forth by the state for network Providers. Payment allowable shall be comparable to what Community pays network Providers, an amount negotiated between Provider and Community, or at the usual and customary rate defined by TDI in 28 T.A.C. Section 11.506. Community will be responsible for payment for out-of-network providers who provide covered services to Members who move out of the service area through the end of the period for which the state has paid Community for that Member’s care. Community expects providers billing for out-of-network emergency care to submit claims within 95 days from the date of service. Community will adjudicate “clean” claims submitted for out-of-network emergency care within 30 days from Community’s receipt of the claim.

**Claims Filing**

Claims must be filed using the current standard CMS 1500 Form or UB-04 Form. Claims must be submitted within 95 days of service.

**Electronic Code Sets and Standard Transactions**

Federal regulations require covered entities (HMOs, physicians, hospitals, labs, pharmacies and other healthcare Providers) to comply with HIPAA-approved transactions and code sets for dates of service on or after October 16, 2003. Community is in compliance with HIPAA EDI requirements for all electronic transactions. Providers should submit electronic claims in accordance with ASCX12 Version 5010 format.
Electronic Medical Claims (Community)

Community receives electronic transactions through four clearinghouses, effective November 1, 2017:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Phone Number</th>
<th>Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Healthcare Solutions, Inc. (formerly Emdeon)</td>
<td>1.800.735.8254</td>
<td>48145</td>
</tr>
<tr>
<td>AVAILITY</td>
<td>1.800.282.4548</td>
<td>48145</td>
</tr>
<tr>
<td>Gateway/Trizetto Provider Solutions</td>
<td>1.800.969.3666</td>
<td>48145</td>
</tr>
<tr>
<td>RelayHealth</td>
<td>1.563.585.4411</td>
<td>48145</td>
</tr>
</tbody>
</table>

Contact your clearinghouses for questions regarding electronic claims submission. You may also contact Community Provider Relations at 713.295.2295 or 1.888.760.2600 or email: providerrelations@communityhealthchoice.org for assistance.

Providers or their billing services may submit electronic claims directly to Community. To request access to direct billing, please forward the following information to the Community Claims Department at Support@communityhealthchoice.org:

- Subject: EDI Claims Direct Submission
- Contact
- Telephone number

A Community representative will contact the Provider’s office and set up direct claims filing with the Provider’s office or billing service.

Electronic Behavioral Health Claims (Beacon Health Options)

Behavioral health claims must be submitted to Beacon Health Options on a standard CMS 1500 Form or UB-92/UB-04. Behavioral Health Providers or their billing services may submit electronic claims through a clearinghouse or through direct billing.

Beacon Health Options receives electronic transactions through these clearinghouses:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Beacon Health Options Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedAvant (ProxyMed)</td>
<td>54160</td>
</tr>
<tr>
<td>AVAILITY</td>
<td>54160</td>
</tr>
<tr>
<td>Change Healthcare Solutions, Inc. (formerly Emdeon) (WebMD Envoy)</td>
<td>54160</td>
</tr>
</tbody>
</table>

To request access to direct billing, please contact the Beacon Health Options Provider Operations Department or your local Provider representative: Beacon Health Options Provider Operations: 1.877.343.3108

Submitting Claims by Mail

Claims may be submitted by mail to the following address:

Community Health Choice
P.O. Box 301404
Houston, TX 77230-1404

Or by Certified mail to the following address:

Community Health Choice
2636 South Loop West, Ste. 125
Houston, TX 77054
Refund Lockbox Address:

Community Health Choice Refund Lockbox
P.O. Box 204014
Houston, TX 77216-4014

Behavioral Health claims may be submitted by mail to the following address:

Beacon Health Options
Attn: Claims Departments
500 Unicorn Park Drive, Ste. 401
Woburn, MA 01801-3393

Claims Appeals

Please refer to the STAR, CHIP and CHIP Perinatal sections of this manual for detailed information on Provider appeal rights for each program.

Community claims appeals should be sent to:

Community Health Choice
Attn: Appeals
2636 South Loop West, Suite 125
Houston, TX 77054

Send behavioral health claims appeals to:

Beacon Health Options
Attn: Claims Departments
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Claims Questions/Status

Providers can now check claims status, Member eligibility and a variety of other services online. You must sign up for this service. To learn more, visit https://www.CommunityHealthChoice.org.

To check status of a claim payment, authorized Providers can either:

Contact Provider Hotline during regular business hours:

Local: 713.295.2295 or Toll-free: 1.888.760.2600
Fax: 713.295.7039

Send inquiries in writing to:

Community Health Choice
Attn: Provider Relations
2636 South Loop West, Ste. 125
Houston, TX 77054

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

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

Contact Beacon Health Options Member Services for inquiries about behavioral health claims at 1.877.343.3108.
Community Provider Portal

Community’s online Provider Portal offers secure, 24 hours a day, 7 days a week access to online tools and services. Providers can submit claims and view claim status, as well as Member eligibility, benefits, and the status of pre-authorizations. To access the Provider Portal: visit www.CommunityHealthChoice.org, click on the Provider tab, then “Register Here”. Complete the Secure Access Application and send it to Community Health Choice. Community will process your form and provide your login credentials within three business days.

Pharmacy Billing and Claims

Pharmacy benefits for Community members are administered by Navitus Health Solutions, a pharmacy benefit management company. For questions related to pharmacy benefits, including participating pharmacies, formulary, preferred drugs, billing, prescription overrides, prior authorizations, quantity limits, or formulary exceptions, please call Navitus Customer Care toll-free at 1.877.908.6023 or visit www.Navitus.com.

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

Billing Members

Member Acknowledgement Statement

A Provider may bill a Member for a claim denied as not being medically necessary or not a covered service if both the following conditions are met:

- A specific service or item is provided at the Member’s request
- The Provider has obtained and kept a written Member Acknowledgement 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 Medicaid Program/Children’s Health Insurance 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.”

“Comprendo que, según la opinión del (nombre del proveedor), es posible que CHIP (Programa de Seguros Médicos para Niños) no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el HHSC o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

Provider may bill the following to a Member without obtaining a signed Member Acknowledgement Statement:

- Any service that is not a benefit of the Member’s enrolled STAR/CHIP/CHIP Perinatal Program or Community’s benefit package (for example, personal care items.)
- All services incurred on non-covered days due to lack of eligibility.
- The Provider accepts the Member as a private pay patient
Private Pay Form Agreement

Providers must advise Members that they are accepted as private pay patients at the time the service is provided and that they will be responsible for paying for all services received. Medicaid and CHIP Members should only be requested to complete private pay agreements in very limited situations. The Member should sign written notification:

Private Pay Agreement

I,______________________________________ understand that the Provider _________________________________ is accepting me as a private pay patient for the period of______________________, and I will be responsible for paying for any service I receive. The Provider will not file a claim to CHIP/STAR for services provided to me.

Signed: _______________________________________________ Dated: ______________________________________

Pacto de Pago Privado

Yo,______________________________________ entiendo que el Proveedor_________________________________ is me está aceptando como paciente de pago privado por el periodo de ________________ , y me hago responsable en pagar por cualquier servicio rendido. El Proveedor no le mandara a CHIP/STAR ningún reclamo por servicios que me rinda

Nombre: _______________________________________________ Fecha: ______________________________________

Reporting Provider or Recipient Waste, Abuse or Fraud

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

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

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

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

- Call the OIG Hotline at 1.800.436.6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:

Community Health Choice
V.P. Compliance & Privacy
2636 South Loop West, Ste. 125
Houston, TX 77054
1.877.888.0002
To report waste, abuse or fraud, gather as much information as possible.

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

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

When reporting about someone who gets benefits, include:

- The person’s name
- The person’s date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud
STAR Program

STAR Program Objectives

Community Health Choice (Community) is proud to participate in the State of Texas Access Reform (STAR) Managed Care Program through a contract with the Texas Health and Human Services Commission (HHSC). Introduced in 1997 in Harris County, the STAR Program was established to explore healthcare delivery systems in Texas counties and examine the effectiveness of managed care models for the Medicaid population.

Under the STAR Program, eligible Medicaid clients choose an MCO and a Primary Care Provider (PCP) to provide all primary care services and to arrange for and coordinate referrals for all medically-necessary specialty services. The objectives of the STAR Program are as follows:

• Improve access to care for STAR Program Members
• Increase quality and continuity of care for targeted Medicaid clients
• Decrease inappropriate utilization of the healthcare delivery system
• Achieve cost-effectiveness and efficiency for the state
• Promote Provider and Member satisfaction

STAR Covered Services

General Description

The following information provides an overview of benefits available to Community Members enrolled in the STAR program. Please refer to the current Texas Medicaid Provider Procedure Manual or go to Web site http://www.tmhp.com for a comprehensive listing of limitations and exclusions that apply to each benefit category:

• Ambulance services
• Audiology services, including hearing aids for adults (hearing aids for children are provided through TMHP and are a non-capitated service)
• Behavioral health services, including: (Provided by Beacon Health Options)
  - Inpatient mental health services, including Freestanding Psychiatric Facilities, psychiatric units of general acute care hospitals, and state operated facilities
  - Psychiatric services
  - Outpatient mental health services
  - Counseling services
• Birthing center services
• Chiropractic services
• Dialysis
• Durable medical equipment and supplies
• Emergency services
• Family planning services
• Home health services
• Outpatient chemical dependency services
• Attention Deficit Hyperactivity Disorder (ADHD) services including medications and follow-up care for children who have been prescribed ADHD medications
• Detoxification services
• Hospital services (inpatient and outpatient)
• Laboratory
• Medical Checkups and Comprehensive Care Program (CCP) services for children (under 21) through the Texas Health Steps Program
• Podiatry
• Prenatal care
• Primary care services
• Radiology, imaging and X-rays
• Specialty physician services
• Therapies – physical, occupational and speech
• Transplantation of organs and tissues
• Texas Health Steps
• Vision, including optometry and glasses (Provided through a delegated entity)

All benefits are subject to the limitations and exclusions as outlined in the current Texas Medicaid Provider Procedures manual.

All out-of-network services, except emergency services, require prior authorization.

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

Family Planning
Family Planning services, including sterilization, are covered STAR Member benefits. Family Planning services can be provided by a physician, mid-level practitioner, and through Family Planning clinics. Medicaid Members are allowed the freedom of choice in the selection of contraceptive methods as medically appropriate. Services are provided regardless of age, marital status, sex, race/ethnicity, parenthood, handicap, religion, national origin or contraceptive preference.

Only Family Planning clients, not their spouses or parents or any other individual, can consent to the provision of Family Planning services funded by Title X, XIX, or combined X and XX funds. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member or other trusted adults.

Sterilization
In the event that a Community STAR Medicaid Member desires sterilization as their method of family planning, the Family Planning Provider should request prior authorization for such services. All prior authorization requests should be accompanied by the requisite, approved current sterilization consent form, available in both Spanish and English on the TMHP website www.tmhp.com. This form requires:

• Signature of Community Member requesting sterilization
• Signature date should not be less than 30 days or more than 120 days from the date sterilization is desired
• Signature of the requesting Provider
Texas Health Steps

THSteps Goals
In Texas, the federally-mandated Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is known as Texas Health Steps (THSteps). The goal of THSteps is to provide early detection and treatment of medical and dental problems to infants, children, teens and young adults (from birth through age 20) who are currently enrolled in Medicaid. The American Academy of Pediatrics (AAP) schedule has been modified to meet federal and state requirements in regards to the components of the visits at specific ages. Please refer to the THSteps section of the current Texas Medicaid Provider Procedures Manual (TMPPM) for more information regarding THSteps and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies.

THSteps Services
THSteps services include:

- Medical checkups
- Immunizations recommended by the CDC advisory committee on immunization practices (ACIP)
- Vision services
- Diagnosis/treatment for defects in vision (including the provision of eyeglasses)
- Dental services (including checkups)
- Hearing services
- Diagnosis/treatment for defects in hearing, including hearing aids
- Comprehensive Care Program services
- Support services

Client notification of services/outreach: THSteps recipients receive verbal and written information about services available through the THSteps Program from THSteps staff, other agencies, the health plan, etc.

Periodicity Schedule
Medical checkups are covered for Members under 21 in accordance with the THSteps Periodicity Schedule. The medical checkup periodicity schedule specifies the ages that medical screens/checkups are to be performed and the required screening protocol. Refer to the TMPPM for detailed information. Medical checkups that are exceptions to the periodicity schedule are covered if they are medically necessary, the child has an environmental risk, when required to meet federal or state exam requirements, or when needed before a dental procedure requiring general anesthesia. Acceptance of THSteps medical checkups (or any other service) is voluntary. Acceptance or refusal of services does not affect eligibility for or benefits of any other Medicaid service.
THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TPPPM) for further detail at: http://www.tmbp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thssteps/providers.shtm.

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: www.dshs.state.tx.us/thssteps/providers_components.shtm. For free online provider education: tshhealthsteps.com.
## THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

### Comprehensive Health Screening: 11 through 20 Years of Age

<table>
<thead>
<tr>
<th>Laboratory Tests</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education/Preventative Guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI/STI Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Laboratory Tests

- Pneumococcal
- Hemoglobin
- Lead
- Complete Blood Count
- Microalbumin
- Total Cholesterol
- Hemoglobin A1c
- Thyroid Function Tests
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Ultrasound
- Electrocardiogram (ECG)
- Echocardiogram
- Pulmonary Function Tests
- Exercise Stress Test
- Brain MRI
- Gastrointestinal Endoscopy
- Colonoscopy
- Bone Density
- Cystic Fibrosis Screening
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening
- Gonorrhea Screening
- Syphilis Screening
- Hepatitis B Vaccination
- Hepatitis C Screening
- Hepatitis A Vaccination
- Varicella Zoster Vaccination
- Haemophilus Influenzae Type B (Hib) Vaccination
- Influenza Vaccination
- Pneumococcal Vaccination
- Meningococcal Vaccination
- Tuberculosis (TB) Screening
- Tdap
- Measles, Mumps, Rubella (MMR)
- Varicella (Chickenpox) Vaccination
- Hepatitis A and B Vaccination
- Human Papillomavirus (HPV) Vaccination
- Chlamydia Screening

### LEGEND OF SYMBOLS

- MANDATORY: The component must be performed at the required age.
- Risk-Based: Components should be performed at risk-based ages, as indicated by the clinician.
- WHEN SYMBOLS APPEAR AT THE SAME AGE FOR DEVELOPMENTAL, MENTAL HEALTH, VISION, HEARING SCREENING, PERFORM THE MOST APPROPRIATE-LEVEL SCREEN.

**Note:** This schedule may be used for other ages, if indicated. For more information, please visit the Texas Health and Human Services Commission website at [https://www.hhs.texas.gov](https://www.hhs.texas.gov). For updates to this schedule, see [https://www.hhs.texas.gov](https://www.hhs.texas.gov).

*THSteps components may be performed in other settings. Please consult the appropriate guidelines.*
Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but it should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual:

1. whose principal employment is in agriculture on a seasonal basis;
2. who has been so employed within the last 24 months;
3. who performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and
4. who establishes for the purposes of such employment a temporary abode.

Role of Texas Health and Human Services Commission (HHSC) THSteps Staff

Upon request, THSteps regional staff (contract and non-contract) can assist Members by providing support services (assistance with medical and dental checkups scheduling and transportation). Recipients in need of additional types of support services are referred for case management services.

Referral Guidelines

Community Members can select any THSteps Provider for a THSteps checkup. Contact Member Services for assistance. No authorization or referral is required for a THSteps checkup. Refer Members to Community Member Services for in-network Provider assistance and to THSteps staff at 1.877.847.8377 for out-of-network medical checkup and dental service Providers.

A major objective of the THSteps Program is diagnosis/treatment of problems discovered during a medical checkup. To establish continuity of care for the Member, the medical checkup Provider can provide treatment for the condition identified. If the THSteps medical checkup Provider is unable to perform the needed follow-up diagnosis/treatment services, the medical checkup Provider is then responsible for referring the Member to a Provider (of the Member’s choice) who is qualified to perform the required service(s). Members needing follow-up diagnosis/treatment services must be referred by their primary care physician.

Reimbursement for Medical Checkups

A complete medical checkup is reimbursed at the Medicaid allowable rate. There is no reimbursement for incomplete medical checkups. Reimbursable procedures that must be performed during a THSteps medical checkup are listed on the periodicity schedule. Separate reimbursement is allowed for oral evaluation and fluoride varnish (OEFV) for certified providers, administration of vaccines, TB skin tests, point-of-care testing for the initial lead screening, and certain developmental screens. Please use appropriate modifiers when forwarding claims for THSteps visits performed by nurses, nurse practitioners or physicians’ assistants.

Registered nurses (RNs) without clinical nurse specialist (CNS), nurse practitioner (NP), or certified nurse midwife (CNM) certification may provide medical checkups only under direct physician supervision.

Immunizations (based on the immunization schedule established by the Advisory Committee on Immunization Practices) are a federal/ state-required component of a THSteps medical checkup. THSteps Providers are not reimbursed for the costs of vaccines administered during a medical checkup as vaccines are available free of charge to Providers through the Texas Vaccines for Children (TVFC) Program. Please refer to the TMPPM or the Texas Department of State Health Services Web site for information on enrolling in the TVFC.

During a medical checkup, providers are reimbursed a separate fee for the administration of each required vaccine given to a Texas Health Steps recipient. Combined antigen vaccines (DTaP-Hib, MMR) are reimbursed as one dose. Recipients are not to be referred to local health departments for their immunizations. Providers are required to submit immunization
information to the Texas Immunization Registry (ImmTrac) when an immunization is given. Written consent must be obtained by Provider from parent or guardian before any information is included in the registry. The consent is valid until Member becomes 18 years of age (those 18 and older may now consent for their records to be maintained in ImmTrac as well). Provider must verify consent before information is included in ImmTrac. If Provider is unable to verify consent, the Provider will be notified by ImmTrac and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac website: http://www.immtrac.tdh.state.tx.us/

A THSteps medical checkup is to be performed within 90 days of a Member's enrollment in Community. As a condition for reimbursement, children younger than age 15 must be accompanied by the parent, guardian or other authorized adult at the medical checkup and dental checkup/services visit.

Documentation of completed Texas Health Steps components and elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

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

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

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

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

3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
   - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
   - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
   - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
   - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.

4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
   - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link
the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

- Anemia screening at 12 months.
- Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
- HIV screening at 16-18 years
- Risk-based screenings include:
  - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

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

6. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.

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

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

**Laboratory Tests**

The Texas Department of State Health Services (TDSHS) Chemistry Laboratory, located in HHSC central office headquarters in Austin, Texas, performs free laboratory testing on blood specimens collected by all THSteps medical checkup Providers. The TDSHS laboratory also furnishes Providers with free laboratory collection supplies and postage-paid mailing containers. The DSHS Women’s Health Laboratory in San Antonio provides collection supplies and processing for STD tests. Tests which are required to be sent to the DSHS labs include gonorrhea/Chlamydia, hemoglobin, and the initial lead test, with the exception of lead testing performed with a point of care device in the provider’s office. For other tests, the client or specimen may be sent to the laboratory of the provider’s choice.

**THSteps Provider Responsibilities**

For more information concerning your responsibilities as a participating provider with the HHSC STAR program please refer to your Texas Medicaid Provider Procedures Manual located on the TMHP website at www.tmhp.com.

THSteps has developed a summary of Texas laws addressing the following legal issues for all THSteps Providers. These include, but are not limited to, the following:

- Newborn Blood Screening, Health and Safety Code, Chapter 33, Vernon’s Texas Codes Annotated Parental Accompaniment, Human Resources Code, §32.024(s), Vernon’s Texas Codes Annotated
- Requirements for Reporting Abuse or Neglect, Providers are required to comply with Family Code Sec. 261.10, Vernon’s Texas Codes Annotated
- Simplified Enrollment, Human Resources Code, §32.025(s), Vernon’s Texas Codes Annotated
- Early Childhood Intervention (ECI), Human Resources Code, §32.025(s), Vernon’s Texas Codes Annotated

**THSteps Screenings for Newborns**

Chapter 33 of the Health and Safety Code and TAC Rules 37.51-37.67 detail the Newborn Screening (NBS) Program. House Bill 790, 79th Legislative Session required the Department of State Health Services to expand the NBS Program. The NBS Program screens for 27 disorders. This panel is recommended by the American College of Medical Genetics (ACMG).

The goals of the Texas Newborn Screening Program are to ensure that:
• Each baby born in Texas receives two newborn screening tests, the first before leaving the hospital (24-48 hours after birth) and the second at one to two weeks of age;
• All infants with an abnormal screen receive prompt and appropriate confirmatory testing; and
• All individuals diagnosed with newborn screening conditions are maintained on appropriate medical therapy.

Healthcare Providers are responsible for the collection, handling and labeling of both the first and second screening specimens; the prompt follow-up testing if indicated by screening results; medical care; and the provision of parent education, support and referral to specialty care when needed.

DSHS Laboratory is responsible for specimen analysis, recordkeeping, quality control of laboratory methods and notification of results to practitioners and case managers. The NBS follow-up team tracks abnormal screens and diagnosed cases, assists in the assurance of appropriate medical care, serves as a source of information for practitioners, parents and the public about the newborn screening disorders and maintains registries of diagnosed cases.

The current Newborn Screening Panel consists of the following:

- CAH
- Hemoglobin SC disease
- PKU
- Sickle beta thalassemia
- Galactosemia
- (5) Amino acidopathies
- Hypothyroid
- (5) Fatty acid oxidation disorders
- Sickle cell disease
- (9) Organic acid disorders
- Sickle cell anemia
- Biotinidase deficiency

Screens are due:

- 1st screen on all babies at 24-48 hours
- 2nd screen on all babies at 1-2 weeks
- Mail to DSHS within 24 hours of collection


**Reporting Immunizations**

As a Community Provider, you can fulfill your immunization reporting obligation by applying to ImmTrac to submit encounters directly. The application is available on the ImmTrac Web site. ImmTrac is a statewide registry and tracking system operated by the DSHS that:

- Consolidates immunization records from multiple Providers into one easily accessible record
- Enables Provider’s participation to review patient immunization histories (provided that the records are forwarded to the system) and enter information on administered vaccines
- Assists Providers in dealing with complex vaccination schedule requirements
- Produces recall and reminder notices for vaccines that are due or overdue

It is critical that Providers register with ImmTrac and report immunization encounters.

Web site: http://www.dshs.texas.gov/immunize/immtrac or E-mail: ImmTrac at ImmTrac@dshs.state.tx.us

**THSteps Vision Screen**

THSteps clients (ages 0 through 20 years of age) receive a vision screen as part of a THSteps medical checkup. The type of screening is based on the client’s age and ability to cooperate. The medical checkup Provider who identifies screening abnormalities should refer the child/ youth for diagnosis and treatment by a specialist.

**Vision Benefits for Children**

THSteps/Medicaid Services provide diagnosis and treatment for vision problems, including eyeglasses for defects in vision. The following eye examination and eyewear services are available for THSteps clients:

- One eye examination with refraction per state fiscal year (September 1–August 21) for the purpose of obtaining eyewear
Exception: The yearly eye exam limitation can be exceeded when the school nurse, teacher or parent requests an exam or if the exam is medically necessary

- Eyeglasses every two years, with no limit on the number of replacements for eyeglasses/contact lenses that are lost or destroyed

Exception: The eyeglass limitation can be exceeded whenever there is a diopter change of 0.5 or more

NOTE: Eyewear must be medically necessary and prescribed by a doctor of medicine (M.D.), doctor of optometry (O.D.) or doctor of osteopathy (D.O.).

**THSteps Comprehensive Care Services**

The Omnibus Budget Reconciliation Act of 1989 expanded EPSDT/THSteps Program benefits to include payment for any federally allowable Medicaid service that is medically necessary to treat or ameliorate a defect, physical or mental illness, or a condition identified during a THSteps medical checkup. Comprehensive Care Program (CCP) services also include treatment of medical and dental problems, regardless of whether a formal THSteps medical or dental checkup has been performed.

As a reminder, families who receive financial assistance from HHSC can receive sanctions for failure to obtain, without good cause, medical checkups and immunizations on a timely basis.

**Community Panel Report**

Your monthly panel reports help identify STAR Members who have THSteps checkups that are due and CHIP Members who are due Well-Child checkups.
**Texas Health Steps Quick Reference Guide**

Remember: Use Provider Identifier • Use Benefit Code EP1

### THSteps Medical Checkups

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>99382</td>
</tr>
<tr>
<td>99383</td>
<td>99384</td>
</tr>
<tr>
<td>99385</td>
<td>99391</td>
</tr>
<tr>
<td>99392</td>
<td>99393</td>
</tr>
<tr>
<td>99394</td>
<td>99395</td>
</tr>
</tbody>
</table>

* For clients who are 18 through 20 years of age, use diagnosis code 33000 or 20000.

### ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00118</td>
<td>Routine newborn exam, birth through 7 days</td>
</tr>
<tr>
<td>Z00111</td>
<td>Routine newborn exam, 8 through 28 days</td>
</tr>
<tr>
<td>Z00129</td>
<td>Routine child exam</td>
</tr>
<tr>
<td>Z00123</td>
<td>Routine child exam, abnormal</td>
</tr>
<tr>
<td>Z00000</td>
<td>General adult exam</td>
</tr>
<tr>
<td>Z00001</td>
<td>General adult exam, abnormal</td>
</tr>
</tbody>
</table>

### THSteps Follow-up Visit

Use procedure code 92211 for a THSteps follow-up visit.

### Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

### Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110. Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U5 modifier.

### Mental Health Screening

Mental Health Screening with the use of the PHQ-9, PSC-17, PSC-35, Y-PSC or CRAFT is reported using procedure code 96160 or 96161. Only one procedure code (96160 or 96161) may be reimbursed per client per lifetime.

### Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

### Point-of-Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

### Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632 or 90633</td>
<td>Hep A</td>
</tr>
<tr>
<td>with (90460/90461 or 90471/90472)</td>
<td></td>
</tr>
<tr>
<td>90620 or 90621</td>
<td>MenB</td>
</tr>
<tr>
<td>with (90460/90461 or 90471/90472)</td>
<td></td>
</tr>
<tr>
<td>90636 with (90460/90461 or 90471/90472)</td>
<td>Hbi-MemCY</td>
</tr>
<tr>
<td>90649, 90650, or 90651 with (90460/90461 or 90471/90472)</td>
<td>HPV</td>
</tr>
<tr>
<td>90630, 90654, 90655, 90656, 90657, 90658, 90659, 90660, 90667, 90668, 90669, 90670 with (90460/90461 or 90471/90472)</td>
<td>Influenza</td>
</tr>
<tr>
<td>90670 with (90460/90461 or 90471/90472)</td>
<td>PCV13</td>
</tr>
<tr>
<td>90680 or 90681 with (90460/90461 or 90471/90472/90473)</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>90696 with (90460/90461 or 90471/90472)</td>
<td>DTap-IPV</td>
</tr>
<tr>
<td>90696 with (90460/90461 or 90471/90472)</td>
<td>Hib</td>
</tr>
</tbody>
</table>

* Indicates a vaccine distributed by TVFC

### Immunizations Administered

#### Immunizations Administered

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632 or 90633 with (90460/90461 or 90471/90472)</td>
<td>Hep A</td>
</tr>
<tr>
<td>90620 or 90621 with (90460/90461 or 90471/90472)</td>
<td>MenB</td>
</tr>
<tr>
<td>90636 with (90460/90461 or 90471/90472)</td>
<td>Hbi-MemCY</td>
</tr>
<tr>
<td>90649, 90650, or 90651 with (90460/90461 or 90471/90472)</td>
<td>HPV</td>
</tr>
<tr>
<td>90630, 90654, 90655, 90656, 90657, 90658, 90659, 90660, 90667, 90668, 90669, 90670 with (90460/90461 or 90471/90472)</td>
<td>Influenza</td>
</tr>
<tr>
<td>90670 with (90460/90461 or 90471/90472)</td>
<td>PCV13</td>
</tr>
<tr>
<td>90680 or 90681 with (90460/90461 or 90471/90472/90473)</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>90696 with (90460/90461 or 90471/90472)</td>
<td>DTap-IPV</td>
</tr>
<tr>
<td>90696 with (90460/90461 or 90471/90472)</td>
<td>Hib</td>
</tr>
</tbody>
</table>

* Indicates a vaccine distributed by TVFC
# Contact Information

**THSteps Medical Checkup Claims Inquiries**  
Call 1-800-757-5691 to obtain answers to questions or determine the status of claims. For managed care clients, contact the client’s MCO.  

**THSteps Website**  
General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources.  
www.dshs.texas.gov/thsteps/default.shtm

**THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form** may be downloaded from the THSteps website at:  
www.dshs.texas.gov/thsteps/forms.shtm

**Online catalog of THSteps publications:**  
www.dshs.texas.gov/thsteps/THStepsCatalog.shtm

**THSteps Outreach & Informing Service**  
Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services.  
1-877-THSteps (847-8377), Monday to Friday, 8am-6pm

**THSteps Online Provider Education Website**  
Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services.  
www.txhealthsteps.com

**Case Management for Children and Pregnant Women**  
(512) 776-2168 | www.dshs.texas.gov/caseman

**Texas Immunization Registry (ImmTrac)**  
1-800-348-9158  
www.dshs.texas.gov/immunize/immtrac/default.shtm

**Texas Vaccines for Children Program (TVFC)**  
1-800-252-9152  
www.dshs.texas.gov/immunize/tvfc/default.shtm

**Early Childhood Intervention (ECI)**  
1-800-628-5115 | hhs.texas.gov/services/disability/early-childhood-intervention-services

**Childhood Lead Poisoning Prevention Program**  
1-800-588-1248 | www.dshs.texas.gov/lead/default.shtm

**Vendor Drug Program (fee-for-service)**  
The Medicaid Vendor Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through Texas Medicaid.

Texas Prior Authorization Call Center:  
1-800-728-3927  
or online: https://paxpress.txpa.hidinc.com
(for prior authorizations of non-preferred drugs only)

General information, covered drug list, online pharmacy, and prescriber searches:  
www.txvendordrug.com  
www.txvendordrug.com/about/policies-and-procedures/ procedure-manual

For managed care clients: Contact the client’s MCO.

**Laboratory**  
The Department of State Health Services (DSHS) Laboratory performs testing for THSteps and NBS clients for the State of Texas. The following provides contact information for ordering laboratory supplies, inquiries on collection, submission and shipping of specimens, and obtaining test results.

**For THSteps**  
Requests for THSteps laboratory supplies should be made on Form G399 and can be submitted to the DSHS Laboratory Container Preparation Group by:

- **Email**: ContainerPrepGroup@dshs.state.tx.us
- **Fax**: (512) 776-7672
- **Phone**: (512) 776-7661 or 1-888-963-7111, Ext 7661
- Specimen shipping questions, call (512) 776-7569 or 1-888-963-7111, Ext 7569
- Specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111, Ext 6236
- Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533
- **Online Results**: Access THSteps test results online using the Results - Web Portal web application for Clinical Chemistry. To gain access, download, complete, and submit the required access forms. They are available at:  
  www.dshs.texas.gov/lab/remotedata.shtm

  - For gonorrhea and chlamydia adolescent screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website:  
    www.dshs.texas.gov/lab/mbcbintro.shtm

  - For HIV screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website:  
    www.dshs.texas.gov/lab/sero_about.shtm

**For NBS**  
A written request for Newborn Screening (NBS) specimen collection form (NBS3) is required. To obtain an order form for written requests, call the Container Preparation Group at (512) 776-7661 or 1-888-963-7111, Ext 766.  
- Specimen submission and testing questions, call (512) 776-7333 or 1-888-963-7111, Ext 7333
- Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533
- **Online Results**: Access Newborn Screening (NBS) test results online using the Texas NBS Web Application. To gain access, download, complete, and submit the required access forms. They are available at:  
  www.dshs.texas.gov/lab/remotedata.shtm

**To Report Potential Medicaid Fraud**  
HHSC Client or Provider Fraud Investigations:  
1-800-436-6184  
www.oig.hhsc.texas.gov

**Comprehensive Care Program (CCP)**  
Telephone: 1-800-846-7470 | Fax: (512) 514-4212

**Medical Transportation Program (MTP)**  
1-877-633-8747  
www.txhealth.org/services/health/medicaid-chip/programs/texas-medicaid-chip-medical-transportation-program

**Texas Medicaid & Healthcare Partnership (TMHP)**  
General Inquiries Line: 1-800-925-9126 | www.tmhp.com
Coordination with Non-Health Plan Covered Services

Community is not responsible for providing the services listed below; we are responsible for appropriate referrals to these services.

THSteps Dental Services

Comprehensive dental benefits are available for THSteps recipients (Medicaid recipients under age 21) through the Member’s selected dental plan and include preventive, therapeutic, orthodontic, and emergency services. THSteps recipients can receive routine periodic dental checkups/exams every six months beginning at one year of age. Treatment services are available at any age.

Each THSteps medical checkup is to include a referral for a dental checkup if a dentist has not seen the Member in the last six months. Although an oral screening examination is part of the physical examination (conducted during a THSteps medical checkup) it does not substitute for a dental checkup/exam by a dentist. Members under 21 years of age may also self-refer for dental care.

THSteps dental providers should submit claims directly to the Member’s dental plan for processing. THSteps dental surgery claims are processed by the Member’s dental plan. Community covers and processes anesthesia and ambulatory care center claims for dental surgeries for Community members.

THSteps Environmental Lead Investigation (ELI)

Children who have confirmed and persistent elevated blood lead levels may require an ELI to determine the source of the lead exposure. An ELI is completed in a Member’s home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the elevated blood lead level.

A physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) who conducts blood lead tests for a THSteps client may submit a request for an ELI after a blood lead test has been conducted and there is evidence of persistent and confirmed elevated blood lead level for the client. The healthcare provider can request an ELI by completing Form Pb-101 “Environmental Lead Investigation Request” and submitting it to the TX CLPPP. TX CLPPP will review the request and determine whether the criteria for an ELI have been met. More information about this process is available in the TMPPM.

Texas Agency Administered Programs and Case Management Services

Community works with Texas Department of Family and Protective Services (DFPS) to ensure that the at-risk population, both children in custody and not in custody of DFPS, receive the services they need.

Children who are served by DFPS may transition into and out of Community more rapidly and unpredictably than the general population, experiencing placements and reunification inside and outside of the Service Area.

During the transition period and beyond, Providers must:

- Provide periodic written updates on treatment status of Members to DFPS as required by DFPS
- Refer suspected cases of abuse or neglect to DFPS
- Contact DFPS for assistance with Members

Essential Public Health Services

Community 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 in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations 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
- Referring to the local Public Health Entity for TB contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
• Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
• Referring for Women, Infants, and Children (WIC) services
• Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
• Reporting of immunizations provided, including parental consent to share data, to the statewide ImmTrac Registry
• Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment
• Referring lead screening tests to the HHSC laboratory

Texas School Health and Related Services (SHARS)

SHARS includes school districts, school cooperatives and individuals who meet state educational agency licensing requirements and provide services determined to be medically necessary and reasonable to Medicaid eligible children with disabilities under age two. Services may include audiology, medical services, occupational therapy, physical therapy, psychological services, speech therapy, school health services, assessment and counseling.

Early Childhood Intervention (ECI) Case Management/Service Coordination

The Texas ECI Program is a statewide system of family-focused comprehensive services for children under age three with developmental delays. A diagnosis is not required prior to referring a Member to ECI. Member from birth to age 3 may be referred if they have medical conditions known to result in delays in development, the family suspects delays in one or more areas of development, or the child exhibits atypical developmental delay. Providers are required, by federal law, to refer children to ECI within 2 working days of identifying a developmental disability of delay. Contact the ECI Referral Line: 1.800.628.5115

Case Management and Service Coordination services are provided to children from newborn to age three with a developmental disability and/or a developmental delay as defined by ECI criteria. Community will educate Network Providers regarding the identification of the Members under age three who have, or are at risk for having, disabilities and/or developmental delays. Educational material developed or approved by the Texas Interagency Council on ECI is utilized for this training. ECI Case Management Providers do not need to enroll with Community. Providers should send claims for ECI case management services to TMHP including those for STAR Members. Refer to the THSteps section of the TMPPM for additional information.

Early Childhood Intervention Specialized Skills Training

SST is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions. SST services are provided by an ECI provider.

Mental Health Rehabilitative (MHR) And Targeted Case Management (TCM)

Members with a chronic mental illness diagnosis or a combination of chronic mental illness may be eligible to receive Mental Health Targeted Case Management services as part of the Texas Medicaid Program. This includes Members under Case Management Services are provided to assist individuals who meet the TDSHS priority population definition for mental illness or mental retardation to gain access to needed medical, social/behavioral, educational and other services and supports. The priority population and service determination includes:

• Service coordination for Members with mental retardation or other related condition,
• Case management for Members with serious emotional disturbance (SED - patient age 20 and under with a mental health problem that severely disrupts their ability to function socially, academically, and emotionally),
• Case management for Members with severe and persistent mental illness (SPMI – patient age 21 and over with severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment)
Functioning is assessed using the Child and Adolescent Needs and Strengths Assessment (CANS) for clients 17 years of age and younger, or the Adult Needs and Strengths Assessment (ANSA) and any necessary supplemental assessments for clients who are 18 years of age and older. Staff administering the assessment instruments must have documentation of current certification through an approved entity in the CANS or ANSA. Providers should contact Beacon Health Options for additional provider eligibility requirements, including DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG) and HHSC-established qualification and supervisory protocols.

Rehabilitative services are provided to persons, regardless of age, who have a single severe mental disorder, excluding mental retardation. MHR services require pre-authorization from Beacon Health Options. More information about MHR and MHTCM services can be found in the TMPPM.

Case Management for Children and Pregnant Women (CPW)

CPW services assist eligible members in gaining access to medically-necessary medical, social, educational and other services. To be eligible, a child must be under age 21, must have a health condition or health risk, must be Medicaid eligible, and must need services to prevent illness or deterioration of his/her condition. Pregnant women must have one or more high-risk medical and/or personal/psycho-social conditions during pregnancy, must be Medicaid eligible, and must need services to prevent illness or deterioration of their condition.

Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program

Children ages birth through 21 years who live in Texas and have vision impairment may be eligible for services through this program. Services include assisting with developing the confidence and competence needed to be an active part of their community, providing support and training in understanding rights and responsibilities throughout the educational process, assisting in the vocational discovery and development process, providing training to increase independence and ability to participate in vocational related activities, and supplying information to families about additional resources.

Texas Commission for The Blind (TCB) Case Management

Texas Commission for the Blind may provide additional case management services to blind or visually impaired limited to one contact per Member per month.

Tuberculosis Services Provided By DSHS-Approved Providers

Covered benefits for Members include education, screening, diagnosis and treatment of tuberculosis (TB). All confirmed or suspected cases of TB must be referred to Department of State Health Services (DSHS) using the forms (TB-400A and TB-400B) and procedures (www.dshs.state.tx.us) for reporting TB adopted by DSHS in accordance with 25 TAC97.

Community will assist providers in reporting all confirmed or suspected cases of TB to the Local Tuberculosis Control Health Authority (LTCHA) within one working day of identification of a suspected case using procedures set up by the Texas Health and Human Services Commission (HHSC). The Texas Medicaid Program mandates direct observed therapy (DOT) and contact investigation by a DSHS-approved provider.

Any Member who is non-compliant, drug resistant or who is or may be posing a public health threat must be reported to HHSC or the LTCHA. Community will cooperate with LTCHA in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

Medical Transportation Program (MTP)

What is MTP?

MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

• Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
• Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
• Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
• Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
• Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
• Advanced funds to cover authorized transportation services prior to travel

Call MTP:
For more information about services offered by MTP, clients, advocates and providers can call the toll-free line at 1.877.633.8747. In order to be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID number or zip code available at the time of the call.

Department of Aging and Disability Services (DADS) Hospice Services
DADS manages the statewide Hospice Program through provider contracts with hospice agencies. Hospice services provide medical, social, and support services to eligible terminally ill patients upon approval, designed to keep clients comfortable and without pain during the last weeks and months before death. The DADS Hospice Program covers services related to the treatment of the client’s terminal illness and certain physician services (not including treatments). This is not a service covered by Community. Direct questions about the hospice program to the Texas Department of Aging and Disability Services Hospice Program at 1.512.438.3519. Services unrelated to the terminal illness are the responsibility of Community.

Admissions to Inpatient Mental Health Facilities as A Condition of Probation
When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

THSteps Personal Care Services (PCS)
PCS is a benefit of CCP for Members who are birth through 20 years of age. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of ADLs, instrumental activities of daily living (IADLs), and health maintenance activities (HMAs) due to a physical, cognitive, or behavioral limitation related to a client’s disability or chronic health condition. PCS are provided by someone other than the responsible adult of the client who is a minor child or the legal spouse of the client. TMHP process PCS claims.

The PCS benefit is available to members who:
• Are birth through 20 years of age.
• Are enrolled with Texas Medicaid.
• Are eligible for CCP.
• Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client’s ability to accomplish ADLs, IADLs, or HMAs.

Special Supplemental Nutrition Program for Women, Infants, And Children (WIC)
Services are provided to women who are pregnant, postpartum (up to six months after delivery) and breastfeeding (up to 12 months after delivery) as well as infants and children up to five years of age who have limited incomes and are determined to be at nutritional risk. Women, infants, and children are automatically considered income eligible for WIC services if they are Medicaid-eligible. Community will provide WIC with the necessary information to determine WIC eligibility. Community will coordinate with existing WIC Providers to ensure access to the Special Supplemental Nutrition Program or provide services through the Community Network.
STAR Complaints and Appeals

Medicaid/STAR Provider Complaints and Appeals Process

Key Terms to Understand
- “Action” is: 1.) the denial or limited authorization of a requested Medicaid service, including type or level of service; 2.) the reduction, suspension or termination of a previously authorized service; 3.) the denial, in whole or in part, of payment for a service; 4.) the failure to provide a service in a timely manner; 5.) the failure of the Community to act within the timeframes of its contract with HHSC. An adverse determination is one type of Action.
- “Adverse Determination” is a decision by the Community that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary or appropriate.
- “Appeal” means the formal process by which a Member, or a Member’s representative, requests a review of a Community Action.
- “Medicaid Complaint” is defined as an expression of dissatisfaction expressed by a complainant, orally or in writing, to Community about any matter related to Community other than an Action. Possible subjects for Complaints include, but are not limited to, the quality of care of services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Medicaid Member’s rights.

Medicaid Provider Complaints Process
A Provider may file a complaint at any time with Community. Send Complaints to:

Community Health Choice
Attn: Services Improvement Team
2636 South Loop West, Ste. 125
Houston, TX 77054
Fax: 713.295.7033
Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Web site https://www.CommunityHealthChoice.org.

Community shall acknowledge all written complaints within five business days. If a Provider’s complaint is oral, Community’s acknowledgement letter shall include a one-page Complaint Form.

Community shall acknowledge, investigate and resolve all complaints no later than the 30th calendar day after the date Community receives written complaint or one-page complaint form from the complainant.

Documentation
Community will retain all Provider complaint documentation, including fax cover sheets, emails to and from Community, and a telephone log of communication related to the complaint.

Medicaid Provider Appeals Process
IMPORTANT REMINDER: NO APPEAL IS NECESSARY FOR CORRECTED CLAIMS. SUBMIT CORRECT CLAIMS TO THE Community CLAIMS ADDRESS.

Adverse Determination Definition
An Adverse Determination means that health care services provided or proposed to be provided are not medically necessary, not appropriate or experimental or investigational. This includes services provided and retrospective appeals.

Please note that an appeal to an Adverse Determination does not involve administrative denials, such as incorrect information on a claim (e.g., tax identification number), timely filing or adjustments to paid claims. The following information will explain how to appeal an Adverse Determination.
**Appeal of an Adverse Determination**

A Provider may request an appeal of an adverse determination orally or in writing within 30 calendar days of the date of Community’s written notification of an adverse determination. Provider appeals must be in writing and accompanied by complete medical records. Appeals can be submitted through the Provider Portal of the Community Web site www.CommunityHealthChoice.org. Providers may request an appeal verbally or in writing:

- **Phone:** 713.295.2295
- **Toll-free:** 1.888.760.2600
- **Fax:** 713.295.7033

If an appeal is received without medical records, Community will send an Acknowledgement Letter requesting complete medical records. Medical records must be received within 10 calendar days from the date of the Acknowledgement Letter. If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing provider.

Community shall investigate and resolve all Provider appeals of Adverse Determinations no later than the 30th calendar day after the date Community receives the written appeal.

Because the appeal involves a question of medical necessity, Community will have a physician review the appeal. This physician will be someone who was not part of the original decision. An Appeal Resolution Letter will be sent to the patient/enrollee or a person acting on the patient/enrollee’s behalf and the provider. The letter will contain:

1. A statement of the specific medical, dental, or contractual reasons for the resolution;
2. The clinical basis for the decision;
3. A description of or the source of the screening criteria that were utilized in making the determination;
4. The professional specialty of the physician who made the determination;
5. Procedures for filing a complaint.

If Community’s decision is upheld during the appeal, a provider may request that the appeal be reviewed by a provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment at issue within 10 working days from the denial of the appeal. The review will be completed within 15 working days of receipt of the request. An Acknowledgement Letter will be sent within five (5) working days of receiving the request of specialty review.

**Expedited Appeals Procedures for Medical Necessity**

You have the right to ask for an expedited appeal for a denial of emergency care, life-threatening conditions or continued hospitalization. This type of appeal is when you feel your patient’s condition could get worse if you wait for the standard appeals process. You may request an expedited appeal, either orally or in writing. Because your appeal involves a question of medical necessity, Community will have a health care provider review the appeal. This health care provider will be someone who has not previously reviewed the case and is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

Community will provide the expedited appeal determination by telephone or electronic transmission and will send a letter within three working days of the initial notification. Community will respond to your expedited appeal based upon the medical or dental immediacy of the condition, procedure, or treatment under review, but the resolution of the appeal will not exceed 72 hours from the date all information necessary to completed the appeal is received by Community.

**Documentation**

Community will retain all Provider appeal documentation, including fax cover sheets, emails to and from Community, and a telephone log of communication related to the appeal.

**Provider Complaints Process to HHSC**

After a Provider has exhausted the appeal process with Community, a Provider has the right to file a complaint with HHSC. Send Provider appeals to HHSC to the following:
Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

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

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

- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.

- The EOB showing the recoupment and/or the plan’s “demand” letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.

- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contracted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

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

STAR Member Complaints and Appeals

Member Complaint Process

How to File a Complaint

Members, or their authorized representatives, may file an oral or written complaint with Community and with Health and Human Services Commission (HHSC). Members may make complaints to Community in writing, sent to the following address:

Community Health Choice
Service Improvement Team
2636 South Loop West, Ste. 125
Houston, TX 77054

Or by calling Community toll-free at 1.888.760.2600. Once a Member has gone through the Community HealthChoice Complaint process, the Member can complain to HHSC, by calling toll-free at 1.866.566.8989 or in writing, emailed to HPM_Complaints@hhsc.state.tx.us or mailed to the following address:

Texas Health and Human Services Commission
Health Plan Operations – H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

Members should provide as much detail as possible describing their complaint. If Providers are involved, the name(s) of each Provider and, if services are involved, a description of the services and the date(s) of service.
Requirements and Timeframes for Filing a Complaint

Members, or their representatives, may file a complaint at any time. If a Member files a written complaint, Community will send the complainant a written acknowledgement within five business days. If a Member files an oral complaint, Community will send a written acknowledgement and a Complaint Form within five business days. Community will resolve Member complaints within 30 calendar days from the date Community receives the complaint. Community will respond to complaints about emergency care in one business day. Community will respond to complaints about denials of continued hospital stays in one business day.

Can someone from Community help my Member file a complaint?

If a Community Member needs assistance filing a complaint, they may call Community Member Services at 713.295.2294 or 1.888.760.2600, and a Community Member Advocate will assist them.

Standard Member Appeals Process

How will I find out if services are denied?

Services that do not meet the criteria of medical necessity may be denied by Community. A denial of this type is called an “adverse determination.” An Adverse Determination is a written notice by Community to deny or limit authorization of a requested service, including the type or level of service; reduce, suspend, or terminate a previously authorized service; deny in whole or in part of payment for service; failure to provide services in a timely manner, the failure of an MCO to act within the timeframes set forth in this agreement and 42 C.F.R. §438.408(b); or for a resident of a rural area with only one MCO, the denial of a Medicaid Member’s request to obtain services outside the Network.

Community will notify the Provider and Member when it issues an Adverse

Determination within three business days by letter to the Provider and Member. If a member is hospitalized at the time of Adverse Determination, Community will notify the Provider by telephone or electronic transmission within one business day, followed by letter to the Member within three business days. If Community is denying post-stabilization care following an emergency, Community shall issue the Adverse Determination by telephone or electronic transmission within one hour of the request.

What can I do if Community denies or limits my Member’s request for a Covered Service

A Member has the right to appeal any services that have been denied by Community that do not meet the criteria of medical necessity. A denial of this type is called an “adverse determination.” An Appeal is considered a disagreement with an Adverse Determination. A Member can request an appeal orally or in writing.

How to File an Appeal

Members, or their authorized representative, have the right to file an oral or written appeal to a Notice of Action with Community. Submit appeals to:

Community Health Choice
Member Appeals Coordinator
2636 South Loop West, Ste. 125
Houston, TX 77054
Phone: 713.295.2294 or 1.888.760.2600
Fax: 713.295.7033

If a Member files a written appeal, Community will send the appellant a written acknowledgement within five business days. If a Member files an oral appeal, Community will send a written acknowledgement and an Appeal Form within five business days. The appellant must return the Appeal Form to document the appeal in writing. If a Member or his/her representative requests an expedited resolution of an appeal, Community will follow the steps in the subsection “Expedited MCO Appeals.”

Members, or their representatives, should provide as much detail as possible describing their appeal. If Providers are involved, the name(s) of each Provider and if services are involved, a description of the services and the date(s) of service. Members must understand that if the appeal decision is adverse to the Member, the Member may be financially
responsible for the services which were the subject of the appeal, including services furnished while the appeal is pending.

**Timeframe for Filing an Appeal**

Members must file a Request for Appeal within 60 calendar days from receipt of a Notice of an Action. To ensure continuation of currently authorized services, a Member must file an appeal on or before the later of: 1.) 10 calendar days following Community's mailing and notice of the action; or 2.) the intended effective date of the proposed action.

**Timeframe for Resolution of an Appeal**

Community will resolve standard appeals within 30 calendar days from the date Community receives the appeal. This timeframe may be extended up to 14 calendar days if: 1.) the Member requests an extension; or 2.) Community advises the Member of a need for additional information and that extending the timeframe may be in the Member's best interest. Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**Can someone from Community help me file an appeal?**

For assistance with an appeal or expedited appeal, call Member Services toll-free 1.888.760.2600. Member Services will connect you to an Appeals Coordinator who will assist you.

**When can a Member request a State Fair Hearing?**

A member can request a State Fair Hearing after Community’s appeals process. You must follow the internal complaint and appeals process before requesting a Fair Hearing. A State Fair Hearing must be requested within 120 days of the appeal decision letter. See “State Fair Hearing Information.”

**Expedited Member MCO Appeal**

**Right to an Expedited Appeal**

A Member, or his/her representative, may request an expedited appeal, if he/she believes that the standard appeal process may seriously jeopardize the Member’s life or health.

**How to File an Expedited Appeal**

Expedited appeals may be requested verbally or in writing. To request an expedited appeal, a Member or his/her representative should send the appeal to the following:

Community Health Choice  
Appeals Department  
2636 South Loop West, Ste. 125  
Houston, TX 77054  
Phone: 713.295.2295 or 1.888.760.2600  
Fax: 713.295.7033

Community will accept expedited appeals 24 hours a day, seven days a week. Requests for expedited appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal.

**Resolution Timeframe for an Expedited Appeal**

Community must complete its investigation and resolution of an appeal concerning an ongoing emergency or continued hospitalization:

1.) in accordance with the medical immediacy of the case; and

2.) not later than one business day after Community receives the request for the expedited appeal.

If the expedited appeal does not involve the above, Community will notify the Member of the outcome of the appeal within 72 hours. This timeframe may be extended up to 14 calendar days if:

1.) the Member requests an extension; or

2.) Community advises the Member of a need for additional information and that extending the timeframe may be in
the Member’s best interest.
Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**What if Community denies the request for an Expedited Appeal?**
If Community determines that a Member’s appeal request does not follow the definition of expedited appeal, it will treat the appeal as a standard appeal. Community shall make a reasonable effort to notify the appellate that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

**Who can help me file an Expedited Appeal?**
For assistance with an appeal or expedited appeal, call Member Services toll-free 1.888.760.2600. Member Services will connect you to an Appeals Coordinator who will assist you.

**State Fair Hearing Information**

**Can a Member ask for a State Fair Hearing?**
If a Member, as a Member of the health plan, disagrees with the health plan’s appeal decision, the Member has the right to ask for a fair hearing. Members must exhaust Community’s appeal process prior to requesting a State fair hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A Provider may be a Member’s representative. The Member or the Member’s representative must ask for the fair hearing within 120 days of the date on the health plan’s letter that tells of the appeal decision being challenged. If the Member does not ask for the fair hearing within 120 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member’s representative should either send a letter to the health plan at:

**Community Health Choice**
**Attn: Member Appeals Coordinator**
2636 South Loop West, Ste. 125
Houston, TX 77054
Or call toll-free at 1.888.760.2600

If the Member asks for a fair hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

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

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

**STAR Member Eligibility and Added Benefits**

**STAR Member Eligibility**

**Determination by HHSC**
Community provides health services for these STAR targeted client groups:

- Individuals receiving Temporary Aid to Needy Families (formerly AFDC) within Harris Counties including Austin, Brazoria, Fort Bend, Brazoria, Galveston, Harris, Matagorda, Montgomery, Waller, and Wharton;
- Individuals receiving Temporary Aid to Needy Families (formerly AFDC) within Jefferson Counties including Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, and Walker
• Women receiving Medicaid benefits as a result of pregnancy in all 20 surrounding counties

The first group is primarily composed of women and their dependent children (who are under the age of 21). This group comprises almost 70% of the entire Medicaid population and has historically been the highest user of healthcare services. As a result, the greatest impact toward achieving the program goals of increased access to care, increased quality of service, improved cost effectiveness and efficiency, as well as Member and Provider satisfaction, can be expected by improving the healthcare delivery system for this large group of clients. This group must enroll in the STAR Program. A Member must meet both the residence and the program qualifications in order to be a participant in STAR.

Individuals interested in receiving information about the STAR Program should call the state contracted enrollment broker. Individuals who need to enroll in the STAR Program or change their health plan should also contact the State Enrollment Broker at 1.800.964.2777. The Texas Health and Human Services Commission has requested that Providers refrain from answering questions or assisting STAR-eligible individuals with the actual enrollment process for the STAR Program. Please direct these individuals to the enrollment broker for assistance.

**Adoption Assistance and Permanency Care Assistance (AAPCA)**

Effective September 1, 2017, Adoption Assistance and Permanency Care Assistance (AAPCA) clients who currently receive Medicaid services through Medicaid fee-for-service will be moved into Managed Care Organizations (MCOs), like Community. Adoption Assistance clients are children who are adopted from foster care. Permanency Care Assistance clients are children who cannot be reunited with their parents and are placed with families who receive financial support to provide a permanent home. Members will be assigned to a specific Medicaid program (STAR or STAR Kids), based on health and income status. Community does not participate in STAR Kids. Members assigned to Community will receive the same benefits as existing STAR Members. Members assigned to Community will have the same Community STAR ID card as existing STAR Members. Members that will be assigned to Community (and subsequently may become your patients) do not receive Supplemental Security Income (SSI), Medicare, or 1915(C) waiver services; do not have a disability as determined by the U.S. Social Security Administration or the State of Texas; and do not live in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID).

**Span of Eligibility**

A Member can change health plans by calling the Texas Medicaid Managed Care Hotline at 1.800.964.2777. However, a Member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a Member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If a request for a plan change is made on or before April 15th, the change will take place on May 1st.
- If a request for plan change is made after April 15th, the change will take place on June 1st.

**Verifying Member Medicaid Eligibility**

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

- Swipe the patient’s Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at www.tmhp.com
- Call the Your Texas Benefits provider helpline at 1.855.827.3747.
- Call Provider Services at the patient’s medical or dental plan.

**Important:** Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1.855.827.3748. Medicaid Members also can go online to order new cards or print temporary cards.

**Important:** Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted
by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the client’s eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information. Medicaid providers can log into the site to see a patient’s Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub – regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It’s FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the “Initial Registration Guide for Medicaid Providers”. For more information on how to get registered, download the “Welcome Packet” on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
  - Vaccinations
  - Prescription drugs
  - Past Medicaid visits
  - Health Events, including diagnosis and treatment, and
  - Lab Results
- Verify a Medicaid patient’s eligibility and view patient program information
- View Texas Health Steps Alerts
- Use the Blue Button to request a Medicaid patient’s available health information in a consolidated format

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more.

If you have questions, call 1.855.827.3747 or email ytb-card-support@hpe.com.
Verifying Community Member Eligibility

All Community Members are issued a Your Texas Benefit Medicaid Card or Temporary ID (Form 1027-A) as well as a Community Member ID Card.

When verifying Member eligibility, ask for your patient’s Community Member ID Card and their Your Texas Benefit Medicaid Card. Make a copy of both sides of the card for the Member’s file. Before providing services, verify that you have received an authorization number for inpatient or selected outpatient services. Failure to obtain authorization may result in a denial by Community. To verify Community Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community Member Services at 713.295.2294 or 1.888.760.2600. You can check eligibility, benefits and Primary Care Provider selection.
- Providers may also contact the TMHP Automated Inquiry System (AIS) at 1.800.925.9126, by using the secure Web site http://www.hhsc.state.tx.us/index.shtml, and by visiting TexMedConnect provider portal on the TMHP Web site.
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)

Be sure to have the following information when you call or go to Community Online:

- Member’s name
- Member’s ID number
- Member’s designated Primary Care Provider

Community Member ID Card

When a Community Member visits your office, make a copy of both sides of their Community Member ID Card and the Your Texas Benefit Medicaid Card. Please note that although the Community Member ID Card identifies a Community Member, it does not confirm eligibility or guarantee eligibility for benefits coverage or payment.

The Community Member ID Card contains the following information:

- Member name
- Member ID number
- Member date of birth
- PCP effective date

Member ID Card for Newborns

In the case of newborns, Community will issue the newborn an ID card with the temporary “proxy” number. This is the mother’s ID number with a suffix attached. Use this number on all claims until a state-issued Medicaid number is available.
When the state issues and informs Community of the newborn’s Medicaid ID number, we will reissue a new Community Member ID card with the new Medicaid ID number. The Medicaid ID form will have “STAR Community” printed in the upper right portion of the form. Each STAR Program Member in the household/case will appear on the form. Immediately under the Member name, the name of the Member’s plan will be printed. In addition, there will be an indication if the Member is eligible for the Texas Health Steps Medical Screen or Dental Services Program.

**Temporary Medicaid ID Verification 1027-A**

Members who lose the Texas Benefits Medicaid Card can obtain a temporary proof of Medicaid eligibility: Form 1027-A. Form 1027-A lists each eligible family member and has a “through” date, indicating the last day it may be used. Members should use this temporary eligibility to obtain healthcare services until a replacement Texas Benefits Medicaid Card is received.

**Pharmacy Services**

Members will also use their Your Texas Benefit Medicaid Card for pharmacy services under Navitus Health Solutions effective March 1, 2012. There will be no prescription limit for STAR Members of any age. See Pharmacy section of this manual for more information on Pharmacy Services.

**Member Selection/Assignment of a Primary Care Provider**

All Members are given the option of selecting a health plan and a Primary Care Provider. If a Member does not select a Primary Care Provider, Community will auto-assign a Primary Care Provider, taking into consideration any prior Member/Provider relationships and the Member’s home address. Members may change their Primary Care provider at any time, and those changes are effective the first day of the following month. Limitations to Member selecting a specific Primary Care Provider could include:

- That Provider panel is full
- Provider is no longer participating with Community

**Additional Benefits of the STAR Program**

**Spell-of-Illness Limitation**

There is no spell-of-illness limitation for adults enrolled in managed care.

**Unlimited Prescriptions**

All Community Members receive unlimited, medically-necessary prescriptions.

**Annual Limit on Inpatient Services**

$200,000 annual limit on inpatient services does not apply for STAR Members.

**Value-Added Services**

Community offers Value-Added Services to our Medicaid Members to enhance the value of our managed care product

- **24-Hour Nurse Help line**
  Members can call our Nurse Help line 24 hours a day, seven days a week toll-free at 1.888.332.2730. A nurse will answer Members’ healthcare questions and can help Members get the healthcare they need

- **Dental Benefits: Age 21 and above**
  Dental benefits for Members 21 and over including exams, cleaning, and non-surgical extractions. All other dental services have a 25% discount. Call STARDent toll-free at 1.866.844.4251 to find a network dentist.

- **Vision Benefits**
  Members will receive $100 off the cost of contact lenses instead of glasses, if they choose. The $100 discount only
applies if contact lenses are not covered as part of the standard Medicaid benefit. Members get the $100 discount at the time they are eligible for new eyewear. Members are eligible for eyewear every 24 months.

- **Transportation Services**
  Community offers free transportation for Medicaid Members to doctors’ appointments when State Medical Transportation is not available and when approved by Community’s case manager. The Member must call Community for approval at least three business days before the Member’s appointment.

- **Care Management Program**
  Community has care management programs (including services) for asthma and diabetes. Community gives educational books on asthma, childbirth, and diabetes to Members in our Care Management Programs.

- **Childbirth Classes**
  Classes are offered to Members at multiple sites and at the Community office, at no cost. This is available only in the Harris Service Area. Transportation assistance available in the Harris Service Area.

- **Sports and School Physicals**
  Community will pay network Providers for sports and school physicals for Medicaid Members age 4 to 19, limited to one per year (CPT code 97169, 97170, 97171, 97172 depending on the level of complexity).

- **Boys and Girls Club Membership**
  Basic Boys and Girls Club membership for Members ages 7–17 at no cost. Limitations may apply.

- **Neighborhood Centers, Inc. (NCI) Membership**
  Community will pay $100 towards the membership cost, once per year, to the Neighborhood Centers, Inc. (NCI) of choice for Medicaid Members in the Harris Service Area. The membership only covers health and wellness classes. Limitations may apply.

- **Youth Sports League Fee Allowance**
  Community will pay up to $40 annually toward the cost of a Member’s registration fee for a youth sports league.
STAR Member Rights and Responsibilities

STAR Member Rights

• You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
  - be treated fairly and with respect; and
  - know that your medical records and discussions with your Providers will be kept private and confidential.

• 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:
  - be told how to choose and change your health plan and your Primary Care Provider;
  - choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan;
  - change your Primary Care Provider;
  - change your health plan without penalty; and
  - be told how to change your health plan or your Primary Care Provider.

• You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
  - 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; and
  - be told why care or services were denied and not given.

• You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - work as part of a team with your Provider in deciding what healthcare is best for you; and
  - say yes or no to the care recommended by your Provider.

• 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 and fair hearings. That includes the right to:
  - make a complaint to your health plan or to the state Medicaid program about your healthcare, your Provider or your health plan;
  - get a timely answer to your complaint;
  - use the plan’s appeal process and be told how to use it; and
  - ask for a fair hearing from the state Medicaid program and get information about how the process works.

• You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - have telephone access to a medical professional 24 hours a day, seven days a week, to get any emergency or urgent care you need;
  - get medical care in a timely manner;
  - 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;
  - 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; and
  - be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

• 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

• 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.
• 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

**STAR Member Responsibilities**

• You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
  - learn and understand your rights under the Medicaid program;
  - ask questions if you do not understand your rights; and
  - learn what choices of health plans are available in your area.

• You must abide by the health plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
  - learn and follow your health plan’s rules and Medicaid rules;
  - choose your health plan and a Primary Care Provider quickly;
  - make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan;
  - keep your scheduled appointments;
  - cancel appointments in advance when you cannot keep them;
  - always contact your Primary Care Provider first for your non-emergency medical needs;
    - be sure you have approval from your Primary Care Provider before going to a specialist; and
    - understand when you should and should not go to the emergency room.

• You must share information about your health status with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
  - tell your Primary Care Provider about your health;
  - talk to your Providers about your healthcare needs and ask questions about the different ways your health care problems can be treated; and
  - help your Providers get your medical records.

• You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
  - work as a team with your Provider in deciding what health care is best for you;
  - understand how the things you do can affect your health;
  - do the best you can to stay healthy;
    - treat Providers and staff with respect; and
    - talk to your Provider about all of your medications.

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

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

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

• Getting paid for services that weren’t given or necessary
• Not telling the truth about a medical condition to get medical treatment
• Letting someone else use their Medicaid or CHIP ID
• Using someone else’s Medicaid or CHIP ID
• Not telling the truth about the amount of money or resources he or she has to get benefits.
To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:

  Community Health Choice  
  V.P. Compliance & Privacy  
  2636 South Loop West, Ste. 125  
  Houston, TX 77054  
  1.877.888.0002  

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

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

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

When reporting about someone who gets benefits, include:

- The person’s name
- The person’s date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Member’s Right to Designate An OB/GYN

Community allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member’s Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to specialist doctor within the network

Billing Members

Medicaid providers are prohibited from billing Medicaid recipients unless certain conditions are met as outlined in the Texas Medicaid Provider Procedures Manual. Providers may NOT request payments from Community STAR Members. There are no co-payments for Medicaid Members. Community STAR Members cannot be billed for any services covered by either the STAR program or Community. (1 TAC 15 354.1005)
Reporting Abuse, Neglect, Or Exploitation (ANE)

Report suspected Abuse, Neglect, and Exploitation
MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:
- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers
Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:
- An adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
  - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
  - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - a managed care organization;
  - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option
Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:
- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

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

Abuse, Neglect, and Exploitation Report Findings
Provider must provide Community with a copy of the abuse, neglect, and exploitation findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).
STAR Enrollment and Disenrollment from Community

**Enrollment**

**Pregnant Women**

Within 15 days of receipt, HHSC will process Medicaid applications for pregnant women. Once an applicant is certified as eligible, a Your Texas Benefit Medicaid ID card will be issued to verify eligibility and to facilitate Provider reimbursement. Community will also be informed of new Members on a daily basis. Community will mail a New Member Welcome Packet with a Community Identification Card. Temporary cards will be sent to Members without Primary Care Provider designations while Community attempts to call the Member.

Community’s Member Services Representative will attempt to call all new Members received on the daily files to confirm that they are currently accessing prenatal care. During this call, the Community representative will help the new Member arrange her first prenatal appointment if she is not currently seeking care. A brief risk assessment of the woman’s pregnancy will be done to determine whether Community Case Management should get involved. The pregnancy care provider that the woman is seeing will be contacted if Case Management is actively working with a woman. Physicians should also expect contact from Community to facilitate prenatal appointments for new Community Members. Physicians and other pregnancy care providers are encouraged to make prenatal appointments within two weeks or as soon as possible.

To ensure proper billing, physicians should call the TMHP eligibility line at 1.800.925.9126 to obtain the name of the patient’s plan, if not identified on the Member’s Your Texas Benefit Medicaid ID, or if Member does not yet have a card. Community requires prior authorization for hospital and professional service beyond the 48/96-hour time limits on vaginal and C-section deliveries.

**Newborns**

Newborns are automatically enrolled in the mother’s plan for 90 days. Community will work with expectant mothers to choose a Primary Care Provider for their newborns prior to birth or, as soon as possible, after the birth.

Once a Medicaid eligible baby’s birth is reported, HHSC will issue the newborn a Medicaid ID number. If a newborn is a Member of a Medicaid MCO and the state issued Medicaid ID number is not available, the claims should be billed using the mother’s name and Medicaid ID number. Pediatric specialists also should use this billing process. Providers should contact Community for specific billing procedures.

Community will issue a temporary “proxy” number for the newborn, until the state issued ID number is available. All claims filing deadlines remain the same. To ensure that all claims are paid in a timely fashion and our Members are seen, Community requests the assistance of all Providers involved in the birth of the newborns to assist and encourage the reporting hospitals, birthing centers, etc., to report all births as soon as possible.

Community will pay newborn claims submitted with proxy number or with new Medicaid number. The system will automatically adjust Membership numbers as appropriate. All newborns remaining in the hospital after mother’s discharge or admitted to Level 2 or higher care must have authorization. Call Community Health Services immediately for authorizations.

**Automatic Reenrollment**

Community Members who lose Medicaid eligibility, and then regain eligibility within six months of their termination date, will automatically be reassigned to Community and their most recent Primary Care Provider. Members may change their plan by calling the STAR program at 1.800.964.2777.

**Disenrollment**

If a Medicaid Member loses Medicaid eligibility, disenrollment may occur. Community may also request disenrollment of a Member from Community, subject to HHSC approval, for the following reasons:

- Fraud in the use of services or facilities
- Fraud or intentional material misrepresentation
• Misconduct that is detrimental to safe Community operations and the delivery of services
• Failure to establish a satisfactory patient/physician or patient/provider relationship
• Member no longer lives or resides in the service area
• Member is not eligible for Medicaid
• Member enrolls in another plan
• Member enters a hospice or long-term care facility

If all reasonable measures to remedy the situation fail, and HHSC approves Community’s request to disenroll a Member, Community must notify the Member of the disenrollment. Community must also notify the member of the availability of the complaint process, if the Member disagrees with the disenrollment decision.

Members requesting disenrollment from STAR are required to provide medical documentation from the Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHSC will make the final determination regarding Member requests for dis-enrollment from STAR.

Providers are prohibited from taking retaliatory action against Members.
Community participates in the Children’s Health Insurance Program (CHIP). CHIP is a health insurance program for children under the age of 19 and is designed for families who earn too much money to qualify for Texas Medicaid programs, yet cannot afford to buy private insurance. CHIP covers services such as hospital care, surgery, X-rays, physical/speech/occupational therapies, prescription drugs, emergency services, transplants and regular health checkups and immunizations.

Under CHIP, eligible clients choose an MCO and a Primary Care Provider (PCP) to provide all primary care services and to arrange for and coordinate referrals for all medically necessary specialty services. The objectives of CHIP are:

- Improve access to care for CHIP Members
- Increase quality and continuity of care for CHIP clients
- Decrease inappropriate utilization of the healthcare delivery system
- Achieve cost-effectiveness and efficiency for the state of Texas
- Promote Provider and Member satisfaction

**CHIP Covered Services**

Covered CHIP services must meet the CHIP definition of medically-necessary covered services. There is no lifetime maximum on benefits; however, 12-month period, enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Please note that if services with a 12-month annual limit are all used within one 12-month enrollment period, these particular services are not available during the second 12-month enrollment period within that annual period. Co-pays apply and vary by schedule; please see the Member’s Community ID card for co-pay amounts.

Co-pays apply until a family reaches its specific cost-sharing maximum. There is no spell-of-illness limitation.

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</strong></td>
<td>• 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 caesarian section.</td>
<td>See Card for copayment per admission.</td>
</tr>
<tr>
<td>• Hospital-provided Physician or Provider services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Semi-private room and board (or private if medically necessary as certified by attending)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General nursing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Special duty nursing when medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ICU and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient meals and special diets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Operating, recovery and other treatment rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia and administration (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings, trays, casts, splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drugs, medications and biologicals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood or blood products that are not provided free-of charge to the patient and their administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>• X-rays, imaging and other radiological tests (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory and pathology services (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Machine diagnostic tests (EEGs, EKGs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oxygen services and inhalation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Radiation and chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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 caesarian section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital, physician and related medical services, such as anesthesia, associated with dental care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • 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. |             |             |
| • 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 or palate;  
  - severe skeletal and/or congenital deviations;  
  - severe facial asymmetry including skeletal and/or congenital origins; and  
  - non-functional full Class II bite relationship and non-functional Class III bite relationship as defined by the American Association of Oral and Maxillofacial Surgeons’ classification of occlusion or malocclusion. |             |             |
| • 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 pro |             |             |
<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</strong>&lt;br&gt;Services include, but are not limited to, the following:&lt;br&gt;• Semi-private room and board&lt;br&gt;• Regular nursing services&lt;br&gt;• Rehabilitation services&lt;br&gt;Medical supplies and use of appliances and equipment furnished by the facility</td>
<td>• Requires authorization and physician prescription.&lt;br&gt;• 60 days per 12-month period limit.</td>
<td>None&lt;br&gt;</td>
</tr>
<tr>
<td><strong>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</strong>&lt;br&gt;• X-ray, imaging, and radiological tests (technical component)&lt;br&gt;• Laboratory and pathology services (technical component)&lt;br&gt;• Machine diagnostic tests&lt;br&gt;• Ambulatory surgical facility services&lt;br&gt;• Drugs, medications and biologicals&lt;br&gt;• Casts, splints, dressings&lt;br&gt;• Preventive health services&lt;br&gt;• Physical, occupational and speech therapy&lt;br&gt;• Renal dialysis&lt;br&gt;• Respiratory services&lt;br&gt;• Radiation and chemotherapy&lt;br&gt;• Blood or blood products that are not provided free-of charge to the patient and the administration of these products&lt;br&gt;• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.&lt;br&gt;• 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:&lt;br&gt;  - dilation and curettage (D&amp;C) procedures;&lt;br&gt;  - appropriate provider-administered medications;&lt;br&gt;  - ultrasounds; and&lt;br&gt;  - histological examination of tissue samples.&lt;br&gt;• 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:</td>
<td>Requires prior authorization and physician prescription.</td>
<td>None for preventive services.&lt;br&gt;$0 copayment for generic drugs.&lt;br&gt;See Card for copayment for brand drugs.</td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>- cleft lip and/or palate; or&lt;br&gt;- severe traumatic, skeletal and/or congenital cranio-facial deviations; or&lt;br&gt;- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td>Requires authorization for specialty services.</td>
<td></td>
</tr>
<tr>
<td>• Surgical implants&lt;br&gt;• Other artificial aids including surgical implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- all stages of reconstruction on the affected breast;&lt;br&gt;- surgery and reconstruction on the other breast to produce symmetrical appearance; and&lt;br&gt;- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/Physician Extender Professional Services include, but are not limited to the following:</td>
<td>Requires authorization for specialty services.</td>
<td></td>
</tr>
<tr>
<td>• American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician office visits, in-patient and outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medications, biologicals and materials administered in Physician’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allergy testing, serum and injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Professional component (in/outpatient) of surgical services, including:&lt;br&gt;- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care&lt;br&gt;- Administration of anesthesia by Physician (other than surgeon) or CRNA&lt;br&gt;- Second surgical opinions&lt;br&gt;- Same-day surgery performed in a Hospital without an overnight stay&lt;br&gt;- Invasive diagnostic procedures such as endoscopic examinations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Covered Benefits**

- 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;
  - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  - 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 caesarian section.

- Physician services medically necessary to sup-port a dentist providing dental services to a CHIP member such as general anesthesia or in-travenous (IV) sedation.

- Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic preg-nancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy in-clude, 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/or palate; or
  - severe traumatic, skeletal and/or congenital cranio-facial deviations; or
  - severe facial asymmetry secondary to skeletal de-fects, congenital syndromal conditions and/or tumor growth or its treatment.

**Limitations**

See Card for copayment for office visit.
Co-pays do not apply to preventive visits or to prenatal visits after the first visit.

**Co-Payments**
## Covered Benefits

### 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.

### Home and Community Health Services

**Home and Community Health Services are provided in the home and community, including, but not limited to:**

- Home infusion
- Respiratory therapy
- Visits for private duty nursing (R.N., L.V.N.)
- Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).
- 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.

## Limitations

- May require prior authorization and physician prescription.
- $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).

## Co-Payments

None

- Requires prior authorization and physician prescription.
- Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker.
- Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.

Services are not intended to replace 24-hour inpatient or skilled nursing facility services.

None
<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
</table>
| **Inpatient Mental Health Services** | • Requires prior authorization for nonemergency services.  
• Does not require PCP referral.  
When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. | See Card for inpatient copayment. |

Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to:

• Neuropsychological and psychological testing.
### Covered Benefits

**Outpatient Mental Health Services**

Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:

- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility
- 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)

### Limitations

- 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 binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

### Co-Payments

See Card for copayment for office visit.

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
</table>
| **Outpatient Mental Health Services** | - 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 binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. | See Card for copayment for office visit. |
| Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:  
- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility  
- 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) | | |
<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Substance Abuse Treatment Services include, but are not limited to:</strong></td>
<td>• Requires prior authorization for nonemergency services. Does not require PCP referral.</td>
<td>See Card for inpatient copayment.</td>
</tr>
<tr>
<td>• Pre-surgical or post-surgical orthodontic services for Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Treatment Services</strong></td>
<td>• Requires prior authorization. Does not require PCP referral.</td>
<td>See Card copayment for office visit.</td>
</tr>
<tr>
<td>Outpatient substance abuse treatment services include, but are not limited to, the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>• Requires prior authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical, occupational and speech therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developmental assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td>• Requires authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>Services include, but are not limited to:</td>
<td>• Services apply to the hospice diagnosis.</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td>• Up to a maximum of 120 days with a 6-month life expectancy.</td>
<td></td>
</tr>
<tr>
<td>Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.</td>
<td>Patients electing hospice services may cancel this election at any time.</td>
<td></td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</strong></td>
<td>- Requires authorization for post-stabilization services.</td>
<td>See Card for copayment for non-emergency ER.</td>
</tr>
<tr>
<td>Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency services based on prudent layperson definition of emergency health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical screening examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stabilization services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency ground, air and water transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>- Requires authorization.</td>
<td>None</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of nonexperimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Benefit</strong></td>
<td>- May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</td>
<td>See Card for copayment for office visit.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One pair of non-prosthetic eyewear per 12-month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health plan may reasonably limit the cost of the frames/lenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>- May require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). May require authorization for additional visits.</td>
<td>See Card for copayment for office visit.</td>
</tr>
<tr>
<td>Covered services do not require physician prescription and are limited to spinal subluxation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation Program</td>
<td>• May require authorization.</td>
<td>None</td>
</tr>
<tr>
<td>Covered up to $100 for a 12-month period limit for a plan approved program</td>
<td>• Health Plan defines plan-approved program.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>May be subject to formulary requirements.</td>
<td>None</td>
</tr>
</tbody>
</table>

### CHIP Member Prescriptions

CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

### Community CHIP Value-Added and Extra Benefits

Value-added services are benefits that Community offers to our CHIP Members to enhance the value of our managed care product. Value-added services can change by contract year, so please contact Community for a current list.

- Members can call the Community Nurse Help Line 24 hours a day, seven days a week. Nurses will answer Members’ healthcare questions and help get them the healthcare they need. 1.888.332.2730.

- CHIP Members may elect to receive contact lenses in lieu of eyeglasses as a value-added benefit. This value-added benefit gives CHIP Members age 18 and under a choice between eyeglasses, which are covered as part of the standard benefits package, and contact lenses (one time per year up to $100), which is the value-added benefit. (Medically-necessary contact lenses are covered as part of the standard benefit package. The value-added benefit makes elective contact lenses available as a covered benefit option.)

- Care Management programs (including services) for asthma and diabetes, and a High-Risk Perinatal Program for pregnant mothers with high-risk pregnancies.

- Sport and school physicals for CHIP members ages 4 to 19, are covered by Community as a value-added benefit, limited to one per year, billed with CPT code 97169, 97170, 97171, 97172 depending on the level of complexity.

- Community will provide transportation assistance at no cost to the Member for medical appointments, as determined by Community's case manager. Member must coordinate this service with Community. This service requires Community’s prior authorization at least three business days before the appointment. Available in core service area only: Brazoria, Ft. Bend, Galveston, Harris, Montgomery and Waller counties. Optional: Austin, Chambers, Hardin, Jasper, Jefferson, Liberty, Matagorda, Newton, Orange, Polk, San Jacinto, Tyler, Walker and Wharton counties.

- Free Neighborhood Centers Inc. (NCI) membership to participate in health and wellness classes.

- Children 7-17 years old can join the Boys and Girls Club in their area for free.

- Community will pay up to $40 annually toward the cost of a Member’s registration fee for a youth sports league.

- Community will pay up to $150 in medically approved coverage for any non-covered tobacco cessation programs, prescriptions, and products.

### Health Education Program

Community provides health fairs and wellness screenings, to help Community Members learn to stay healthy. Care Management

- Community’s Care Management Program to Members with diabetes, asthma, or high-risk pregnancies. Community nurses will help Members learn about these illnesses.

- Answer Members’ questions

- Give Members advice
• Send materials to Members
• Find the best doctors to help Members
• Make appointments for Members

Community also works closely with pregnant Members and their newborns.

The Community pregnancy program assists Members and their newborns through the term of their pregnancy. We will help them find an OB/GYN if they do not have one, find a pediatrician for their baby, even help them select the hospital or midwife for the delivery of the baby.

Childbirth Classes

Community offers free childbirth classes at multiple sites and at the Community office. Classes focus on labor and delivery, ways to manage labor pain, breastfeeding, and more. Members who attend the class will get to attend a baby shower. Transportation assistance is available in the Harris Service Area. To R.S.V.P., find a class location near you or get more information, call 713.295.2222 or toll-free at 1.877.635.6736.

Kids Club

Kids Club is free for Members ages 2–12. Kids Club offers health information and vital reminders about preventive checkups. Members also receive newsletters geared to helping kids get “hip on health” and to remind parents of safety and health tips. Community Members receive invitations to family-fun events like Moody Gardens, Astros games and others.

Assistance with CHIP Renewal

Community offers personal assistance at renewal time for Members. Keeping benefits going is vital, and the renewal process can be confusing. Community offers meetings and personal help when it is time to renew.

If Members enrolled with Community need assistance with the filing process, they can call 713.295.2222 or 1.877.635.6736, and Community will let them know about meetings in their area or will assist them over the phone.

Members can also call the CHIP Help Line at 1.800.647.6558 or Community Member Services to receive a CHIP application.

Community Workers

Community has community workers who can help Members with special needs and those needing assistance locating community resources.

CHIP 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
• Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
• Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
• 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, unless otherwise pre-authorized by Health Plan
• 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 the Health Plan 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 the Health Plan
• 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)
• 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 purposes
• Custodial care (care that assists a child 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 parent). This care does not require the continuing attention of trained medical or paramedical personnel. This exclusion does not apply to hospice.
• Housekeeping
• Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
• Services or supplies received from a nurse, which do not require the skill and training of a nurse
• Vision training and vision therapy
• Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
• Donor non-medical expenses
• Charges incurred as a donor of an organ when the recipient is not covered under this health plan
• Educational testing and treatment, evaluation and treatment of learning disabilities

### CHIP DME/Supplies

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Covered</th>
<th>Excluded</th>
<th>Comments/Member Contract Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td></td>
<td>X</td>
<td>Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs (diabetic)</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply not covered, unless RX</td>
</tr>
<tr>
<td>provided at time of dispensing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td></td>
<td>X</td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td></td>
<td>X</td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>Item</td>
<td>Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm Sling</td>
<td>Dispensed as part of office visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td>Over-the-counter supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batteries – initial</td>
<td>For covered DME items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td>For covered DME when replacement is necessary due to normal use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Betadine</td>
<td>See IV therapy supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinitest</td>
<td>For monitoring of diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td>See Ostomy Supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication Devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td>Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diapers/Incontinent Briefs/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chux</td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Contraceptives are not covered under the plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastix</td>
<td>For monitoring diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet, Special</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>Eligible for coverage only if receiving covered home care for wound care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Molds</td>
<td>Custom made, post inner or middle ear surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrodes</td>
<td>Eligible for coverage when used with a covered DME.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enema Supplies</td>
<td>Over-the-counter supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Enteral Nutrition Supplies</strong></td>
<td>X</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Eye Patches</strong></td>
<td>X</td>
<td>Covered for patients with amblyopia.</td>
<td></td>
</tr>
</tbody>
</table>
| **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 blenderized 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 parenterally. |
<p>| <strong>Gloves</strong> | X | Exception: Central line dressings or wound care provided by home care agency. |
| <strong>Hydrogen Peroxide</strong> | X | Over-the-counter supply. |
| <strong>Hygiene Items</strong> | X | |
| <strong>Incontinent Pads</strong> | X | Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan. |
| <strong>Irrigation Sets, Wound Care</strong> | X | Eligible for coverage when used during covered home care for wound care. |
| <strong>Insulin Pump (External) Supplies</strong> | X | Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item. |
| <strong>Irrigation Sets, Urinary</strong> | X | Eligible for coverage for individual with an indwelling urinary catheter. |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Availability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td>X</td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td>X</td>
<td>Eligible for individuals with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Needles and Syringes/ Diabetic</td>
<td>X</td>
<td>See Diabetic Supplies Needles and Syringes/IV and Other</td>
</tr>
<tr>
<td>Central Line</td>
<td>X</td>
<td>See IV Therapy and Dressing Supplies/Central Line</td>
</tr>
<tr>
<td>Needles and Syringes/ Other</td>
<td>X</td>
<td>Eligible for coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td>X</td>
<td>See Saline, Normal</td>
</tr>
<tr>
<td>Novopen</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>X</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.</td>
</tr>
<tr>
<td>Parenteral Nutrition/ Supplies</td>
<td>X</td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td>X</td>
<td>Eligible for coverage:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) when used to dilute medications for nebulizer treatments;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) as part of covered home care for wound care; for indwelling urinary catheter irrigation.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stump Socks</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suction Catheters</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td>X</td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Tape</td>
<td>X</td>
<td>See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.</td>
</tr>
<tr>
<td>Tracheostomy Supplies</td>
<td>X</td>
<td>Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.</td>
</tr>
<tr>
<td>Under Pads</td>
<td>X</td>
<td>See Diapers/Incontinent Briefs/Chux.</td>
</tr>
<tr>
<td>Unna Boot</td>
<td>X</td>
<td>Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.</td>
</tr>
<tr>
<td>Urinary, External Catheter &amp;</td>
<td>X</td>
<td>Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan.</td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary, Indwelling Catheter &amp;</td>
<td>X</td>
<td>Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.</td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary, Intermittent</td>
<td>X</td>
<td>Cover supplies needed for intermittent or straight catherization.</td>
</tr>
<tr>
<td>Urine Test Kit</td>
<td>X</td>
<td>When determined to be medically necessary.</td>
</tr>
<tr>
<td>Urostomy supplies</td>
<td>See Ostomy Supplies.</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Irrigation Sets, Wound Care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eligible for coverage when used during covered home care for wound care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eligible for coverage for individual with an indwelling urinary catheter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Coordination with Non-CHIP Covered Services

Community is not responsible for providing the services listed below, but is responsible for appropriate referrals for these services.

#### Texas Agency Administered Programs and Case Management Services

Community will cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

Children who are served by TDFPS may transition into and out of Community more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the service area.

During the transition period and beyond, Providers must:

- Provide medical records to TDFPS
- Recognize suspected cases of abuse or neglect and appropriately refer to TDFPS
- Schedule medical and behavioral health services appointments within 14 days, unless requested earlier by TDFPS

#### Essential Public Health Services

Community 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 in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations 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
- Referring to the local public health entity for TB contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring to the local public health entity for STD/HIV contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring for Women, Infant and Children (WIC) services
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- 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
- Referring lead screening tests to the TDSHS laboratory
CHIP Complaints and Appeals

CHIP Provider Complaints and Appeals

Key Terms to Understand

1. “Adverse determination” is a decision by the Community that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary or appropriate.

2. “Appeal” means the formal process by which Community addresses adverse determinations.

3. “CHIP or CHIP Perinatal Complaint” is defined as any dissatisfaction, expressed by a complainant, orally or in writing to Community, with any aspect of the Community’s operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or dis-enrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

CHIP and CHIP Perinatal Provider Complaints Process

A Provider may file a complaint at any time with Community. Send complaints to:

Community Health Choice
Attn: Service Improvement Team
2636 South Loop West, Ste. 125
Houston, TX 77054
Fax: 713.295.7033
Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Web site https://www.CommunityHealthChoice.org.

Community shall acknowledge all written complaints within five (5) business days. If a Provider’s Complaint is oral, Community’s Acknowledgement Letter shall include a one-page Complaint Form.

Community shall acknowledge, investigate, and resolve all complaints not later than the 30th calendar day after the date Community receives the written complaint or one-page Complaint Form from the complainant.

Community Provider Appeals Process

IMPORTANT REMINDER: NO APPEAL IS NECESSARY FOR CORRECTED CLAIMS; SUBMIT TO THE Community CLAIMS ADDRESS.

Adverse Determination Definition

An Adverse Determination means that health care services provided or proposed to be provided are not medically necessary, not appropriate or experimental or investigational. This includes services provided and retrospective appeals.

Please note that an appeal to an Adverse Determination does not involve administrative denials, such as incorrect information on a claim (e.g., tax identification number), timely filing or adjustments to paid claims. The following information will explain how to appeal an Adverse Determination.

Appeal of an Adverse Determination

A Provider may request an appeal of an adverse determination orally or in writing within 30 calendar days of the date on Community’s written notification of an adverse determination. Provider appeals must be in writing and accompanied by complete medical records. Appeals can be submitted through the Provider Portal on the Community Web site at https://www.CommunityHealthChoice.org. You may request your appeal verbally or in writing:
If an appeal is received without medical records, Community will send an Acknowledgement Letter requesting complete medical records. Medical records must be received within 10 calendar days from the date of the Acknowledgment Letter. If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing provider.

Community shall investigate and resolve all Provider appeals of Adverse Determinations not later than the 30th calendar day after the date Community receives the written appeal.

Because the appeal involves a question of medical necessity, Community will have a physician review the appeal. This physician will be someone who was not part of the original decision. An Appeal Resolution Letter will be sent to the patient/enrollee or a person acting on the patient/enrollee’s behalf and the provider. The letter will contain:

(A) a statement of the specific medical, dental, or contractual reasons for the resolution;

(B) the clinical basis for the decision;

(C) a description of or the source of the screening criteria that were utilized in making the determination;

(D) the professional specialty of the physician who made the determination;

(E) notice of the appealing party’s right to seek review by a Texas Department of Insurance approved Independent Review Organization (IRO).

(F) notice of the independent review process;

(G) a copy of a request for a review by an IRO form; and

(H) procedures for filing a complaint

If Community’s decision is upheld on appeal, a provider may request that the appeal be reviewed by a provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment at issue within 10 working days from the denial of the appeal. The provider must set forth in writing good cause for having a particular type of specialty provider review the services at issue. The review will be completed within 15 working days of receipt of the request. An Acknowledgement Letter will be sent within five (5) working days of receiving request of specialty review.

Denials of care for emergencies, life-threatening conditions, and denials of continued stays for hospitalized patients may be appealed as an expedited appeal.

Expedited Appeals Procedures for Medical Necessity

You have the right to ask for an expedited appeal for a denial of emergency care, life-threatening conditions or continued hospitalization. This type of appeal is when you feel your patient’s condition could get worse if you wait for the standard appeals process. You may request an expedited appeal, either orally or in writing. Because your appeal involves a question of medical necessity, Community will have a health care provider review the appeal. This health care provider will be someone who has not previously reviewed the case and is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

Community will provide the expedited appeal determination by telephone or electronic transmission and will send a letter within three working days of the initial notification. Community will respond to your expedited appeal based upon the medical or dental immediacy of the condition, procedure, or treatment under review, but the resolution of the appeal will not exceed 72 hours from the date all information necessary to complete the appeal is received by Community.

If Community upholds its original Adverse Determination, you may request a review from a TDI approved independent review organization (IRO). You may request a review by a specialist in the same or similar specialty, within ten (10) working days from the date of the last denial. You must state in writing good cause for having a particular type of provider review the case. The specialist review must be completed within fifteen (15) working days of receipt of the request.

You also have the right to file a complaint about this process. To file a complaint, please contact Community at:
Community must resolve your complaint within thirty (30) days.

**Independent Review Organization (IRO)**

If the appeal of the Adverse Determination is denied, you have the right to request a review of an appeal by a Texas Department of Insurance approved Independent Review Organization (IRO). When Community denies the appeal, you will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process. The IRO will complete its review within 20 days of receipt of the request for IRO review. Request for IRO review, including the IRO form (LHL009), should be submitted to:

**Community Health Choice**  
**Attn: Appeals Department**  
**2636 South Loop West, Ste. 125**  
**Houston, TX 77054**  
**Phone: 713.295.2294**  
**Toll-free: 1.888.760.2600**  
**Fax: 713.295.7033**

In circumstances involving a life-threatening condition, you are entitled to an immediate review by an IRO without having to comply with Community’s procedures for appeal of Adverse Determination. In life-threatening situations, you may contact Community by telephone to request the review by the IRO and Community will provide the required information. The IRO will respond with a determination for reviews of life-threatening conditions within four (4) days of their receipt of the IRO request for expedited review.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review.

**Provider Complaints and Appeals Process to TDI**

A Provider has the right to file a complaint over an appeal with the TDI. Send Provider complaints or appeals to:

**Texas Department of Insurance**  
**P.O. Box 149104**  
**Austin, TX 78714-9104**  
**Toll-free: 1.512.463.6500 or 1.800.252.3439**  
**Fax: 512.475.1771**  
**Web site: http://www.tdi.state.tx.us**

**CHIP Member Complaints and Appeals**

**Member Complaints Process**

How to file a complaint

Members, or their authorized representatives, may file an oral or written complaint with Community and with TDI.

Members may make complaints to Community in writing, sent to the following address:

**Community Health Choice**  
**Service Improvement Team**  
**2636 South Loop West, Ste. 125**  
**Houston, TX 77054**
Or by calling Community toll-free at 1.888.760.2600.

Members should provide as much detail as possible describing their complaint. If Providers are involved, the name(s) of each Provider and, if services are involved, a description of the services and the date(s) of service. If the complaint is given orally, Community will mail a one-page Complaint Form to the Member. The Member should complete and return the Complaint Form to Community as soon as possible for prompt resolution.

**Can someone from Community help my Member file a complaint?**

If a Community Member needs assistance filing a complaint, they may call Community Member Services at 713.295.2294 or 1.888.760.2600 and a Community Member Advocate will assist them.

**Requirements and Timeframes for Filing a Complaint**

Members, or their representatives, may file a complaint at any time. Community will, no later than the fifth business day after the date of the receipt of the complaint, send to the Member a letter acknowledging the date the complaint was received. If the complaint was received orally, Community will include a one-page Complaint Form stating that the Complaint Form should be returned to Community for prompt resolution.

After Community receives the complaint, Community will investigate and send Member a Resolution Letter. The total time for acknowledging, investigating and resolving Member complaints will not exceed 30 calendar days after the date Community receives the Member complaint.

Member complaints concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of the Member complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Members may use the appeals process to resolve a dispute regarding the resolution of a Member complaint.

**Filing Complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints through Community’s complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091. Complaints to the Texas Department of Insurance may also be filed electronically at http://www.tdi.state.tx.us.

**Member Complaint Appeals to Community**

If the Member complaint is not resolved to the Member’s satisfaction, the Member has the right either to appear in person before a Complaint Appeal Panel where the Member normally receives health care services, unless another site is agreed to by the Member, or to address a written appeal to the Complaint Appeal Panel. Community will complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for complaint appeal.

**Community Health Choice**

Attn: Service Improvement Team

2636 South Loop West, Ste. 125

Houston, TX 77054

713.295.2294 or 1.888.760.2600; TDD 1.800.518.1655

Community will send an Acknowledgment Letter to Member not later than the fifth day after the date of receipt of the request of the complaint appeal.

Community will appoint members to the Complaint Appeal Panel, which will advise Community on the resolution of the dispute. The Complaint Appeal Panel will be composed of an equal number of Community staff, physicians or other Providers, and enrollees. A member of the Complaint Appeal Panel may not have been previously involved in the disputed decision.

Not later than the fifth business day before the scheduled meeting of the Complaint Appeal Panel, unless Member agrees otherwise, Community will provide to Member or Member’s designated representative:

a. any documentation to be presented to the panel by Community’s staff;

b. the specialization of any physicians or Providers consulted during the investigation; and
c. the name and affiliation of each of Community's representatives on the panel.

Member, or Member’s designated representative if Member is a minor or disabled, are entitled to:

a. appear in person before the Complaint Appeal Panel;

b. present alternative expert testimony; and

c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after Member’s request for appeal.

Due to the ongoing emergency or continued hospital stay, and at Member’s request, Community will provide, in lieu of a Complaint Appeal Panel, a review by a physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

**Standard Member Appeals Process**

**How will I find out if services are denied?**

Services that do not meet the criteria of medical necessity may be denied by Community. A denial of this type is called an “adverse determination.” An Adverse Determination is a written notice by Community to deny or limit authorization of a requested service, including the type or level of service; reduce, suspend, or terminate a previously authorized service; deny in whole or in part of payment for service; failure to provide services in a timely manner, the failure of an MCO to act within the timeframes set forth in this agreement and 42 C.F.R. §438.408(b); or for a resident of a rural area with only one MCO, the denial of a Medicaid Member’s request to obtain services outside the Network.

Community will notify the Provider and Member when it issues an Adverse Determination within three business days by letter to the Provider and Member. If a Member is hospitalized at the time of Adverse Determination, Community will notify the Provider by telephone or electronic transmission within one business day, followed by letter to the Member within three business days. If Community is denying post-stabilization care following an emergency, Community shall issue the Adverse Determination by telephone or electronic transmission within one hour of the request.

**What can I do if Community denies or limits my Member’s request for a Covered Service**

A Member has the right to appeal any services that have been denied by Community that do not meet the criteria of medical necessity. A denial of this type is called an “adverse determination.”

An Appeal is considered a disagreement with an Adverse Determination.

A Member can request an appeal orally or in writing.

**How to File an Appeal**

Members, or their authorized representative, have the right to file an oral or written appeal to a Notice of Action with Community. Submit appeals to:

**Community Health Choice**  
**Member Appeals Coordinator**  
**2636 South Loop West, Ste. 125**  
**Houston, TX 77054**  
**Fax: 713.295.7033**

If a Member files a written appeal, Community will send the appellate a written acknowledgement within five business days. If a Member files an oral appeal, Community will send a written acknowledgement and an Appeal Form within
five business days. The appellate must return the Appeal Form to document the appeal in writing. If a Member or his/her representative requests an expedited resolution of an appeal, Community will follow the steps in the subsection “Expedited MCO Appeals.”

Members, or their representatives, should provide as much detail as possible describing their appeal. If Providers are involved, the name(s) of each Provider and if services are involved, a description of the services and the date(s) of service. Members must understand that if the appeal decision is adverse to the Member, the Member may be financially responsible for the services which were the subject of the appeal, including services furnished while the appeal is pending.

**Timeframe for Filing an Appeal**

Members must file a Request for Appeal within 30 calendar days from receipt of a Notice of an Action. To ensure continuation of currently authorized services, a Member must file an appeal on or before the later of: 1.) 10 calendar days following Community’s mailing and notice of the action; or 2.) the intended effective date of the proposed action.

**Timeframe for Resolution of an Appeal**

Community will resolve standard appeals within 30 calendar days from the date Community receives the appeal. This timeframe may be extended up to 14 calendar days if: 1.) the Member requests an extension; or 2.) Community advises the Member of a need for additional information and that extending the timeframe may be in the Member’s best interest. Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**Can someone from Community help me file an appeal?**

For assistance with an appeal or expedited appeal, call Member Services toll-free 1.888.760.2600, and an appeals coordinator will assist them with the appeal.

**When can a Member request a State Fair Hearing?**

A member can request a State Fair Hearing after Community’s appeals process has been exhausted. You must follow the internal complaint and appeals process before requesting a Fair Hearing.

**Expedited Member MCO Appeal**

**Right to an Expedited Appeal**

A Member, or his/her representative, may request an expedited appeal, if he/she believes that the standard appeal process may seriously jeopardize the Member’s life or health.

**How to File an Expedited Appeal**

Expedited appeals may be requested verbally or in writing. To request an expedited appeal, a Member or his/her representative should send the appeal to the following:

Community Health Choice  
Appeals Department  
2636 South Loop West, Ste. 125  
Houston, TX 77054  
Phone: 713.295.2295 or 1.888.760.2600  
Fax: 713.295.7033

Community will accept expedited appeals 24 hours a day, seven days a week. Requests for expedited appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal.

**Resolution Timeframe for an Expedited Appeal**

Community must complete its investigation and resolution of an appeal concerning an ongoing emergency or continued hospitalization:

1.) in accordance with the medical immediacy of the case; and
2.) not later than one business day after Community receives the request for the expedited appeal.
If the expedited appeal does not involve the above, Community will notify the Member of the outcome of the appeal within three business days. This timeframe may be extended up to 14 calendar days if:

1.) the Member requests an extension; or
2.) Community advises the Member of a need for additional information and that extending the timeframe may be in the Member’s best interest.

Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**What if Community denies the request for an Expedited Appeal?**

If Community determines that a Member’s appeal request does not follow the definition of expedited appeal, it will treat the appeal as a standard appeal. Community shall make a reasonable effort to notify the appellate that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

**Who can help me file an Expedited Appeal?**

For assistance with an appeal or expedited appeal, call Member Services toll-free 1.888.760.2600.

**External Review by Independent Review Organization**

An independent review organization (IRO) makes decisions on medical necessity and appropriateness of care. If the appeal of the Adverse Determination is denied, a Member, Member’s designated representative or Member’s Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When Community or Community’s Utilization Review Agent deny the appeal, the Member, Member’s designated representative or Member’s Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a life-threatening condition, Member is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In life-threatening situations, Member, Member’s designated representative or Member’s Physician or Provider of record may contact Community or Community’s Utilization Review Agent by telephone to request the review by the IRO and Community or Community’s Utilization Review Agent will provide the required information. Members may call Member Services and ask for an “Independent Review Organization Form” at 713.285.2294 or 1.888.760.2600.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review.

Community will immediately notify TDI of the request for IRO review. TDI will assign the case to an IRO within one business day. If the IRO requests any information, Community must provide the information to TDI within 3 business days. The IRO must reach a decision within 15 days, but no later than 20 days after the IRO receives the case from TDI. In cases involving life-threatening conditions, the IRO must reach a decision within 5 days, but no later than 8 days after the IRO receives the case from TDI.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review.

An IRO review is not available if Community denies payment for a non-covered service, such as cosmetic surgery. IRO review is also not available if a Member has already received treatment and Community determined that the treatment was not medically necessary.

The appeal procedures described above do not prohibit Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if Member believes that the requirement of completing the appeal and review process places Member’s health in serious jeopardy.
CHIP Member Eligibility and Added Benefits

CHIP Member Eligibility

Children who enroll in CHIP receive 12 months of continuous coverage. Families must re-enroll annually. Eligibility for enrollment in CHIP is determined by the HHSC’s Administrative Services Contractor.

Verifying Eligibility

Member ID Card

All Community Members are issued a Community Member ID Card. When verifying Member eligibility, ask for your patient’s Community CHIP Member ID Card. Make a copy of both sides of the card for the Member’s file. Before providing services, verify that you have received an authorization number for inpatient or outpatient services. Failure to obtain authorization may result in a denial by Community.

Eligibility Verification

To verify Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community online at www.CommunityHealthChoice.org. You will need to fill out the Community Secure Access Application to become an authorized user. Call Community Member Services to get more information. You can check eligibility, benefits and PCP selection online.
- Providers can receive eligibility information by calling the CHIP Provider Eligibility Hotline Monday through Friday 8:00 a.m. to 5:00 p.m. (Central Time). The hotline number is 1.800.647.6558. Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently enrolled CHIP Member, or receive an automated response if the Provider has a CHIP Member ID number.
• Community Member Services at 713.295.2294 or 1.888.760.2600.
• Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)
• Be sure to have the following information when you call or go to Community Online:
  • Member’s name
  • Member’s identification number
  • Member’s designated PCP

Member Selection/Assignment of a Primary Care Provider
All Members are given the option of selecting a Primary Care Provider. If a Member does not select a Primary Care Provider, Community will auto-assign a Primary Care Provider, taking into consideration any prior Member/Provider relationships and the Member’s home address. Members may change their Primary Care provider at any time, and those changes are effective the first day of the following month. Limitations to Member selecting a specific Primary Care Provider could include:
  • That Provider panel is full
  • Provider is no longer participating with Community

Re-Enrollment
Community offers personal assistance at renewal time for Community Members. Keeping benefits active is vital, and the renewal process can be confusing. Community offers meetings and personal help at this difficult time.

If Community Members need assistance with re-enrollment or applying, please have them contact Community at 713.295.2222 or 1.877.635.6736 for assistance.

Pregnant Members and Infants
Providers must contact Community immediately when a pregnant CHIP or Medicaid Member is identified.

When Community receives notice from the guardian of the Member, the Member, or the Member’s physician or Provider that a pregnancy has been diagnosed, Community will notify the HHSC Administrative Services Organization. Depending on Member’s income and family size, the HHSC Administrative Service Organization may notify Member’s guardian or Member about Member’s potential eligibility for Medicaid and of Member’s ability to apply for Medicaid. In that situation, the Administrator will also provide appropriate resource information. A Member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If Member is not eligible for Medicaid, the Administrator will extend Member’s eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the month of the baby’s birth.

Newborns born to CHIP Members are automatically enrolled in the mother’s CHIP plan. Infants that are Medicaid eligible are not eligible for CHIP.

For this reason, it is critical that Providers notify Community immediately upon learning about a CHIP Member’s pregnancy and/or delivery.
CHIP Member Rights and Responsibilities

Member Rights

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

2. Your health plan must tell you if they use a “Limited Provider Network.” This is a group of doctors and other Providers who only refer patients to other doctors who are in the same group. “Limited Provider Network” means you cannot see all the doctors who are in your health plan. If your health plan uses “limited networks,” you should check to see that your child’s Primary Care Provider and any specialist doctor you might like to see are part of the same “limited network.”

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

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

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

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

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child’s Primary Care Provider. Ask your health plan about this.

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

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

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

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

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

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

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

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

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

17. You have the right to a fair and quick process for solving problems with your health plan and the plan’s doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

18. You have a right to know that doctors, hospitals and others who care for your child can advise you about your child’s health status, medical care and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals and others cannot require you to pay any other amounts for covered services.

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

2. You must become involved in the doctor’s decisions about your child’s treatments.

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

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

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

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

7. If your child has CHIP, you are responsible for paying your doctor and other Providers co-payments that you owe them. If your child is getting CHIP Perinatal Program services, you will not have any co-payments for that child.

8. You must report misuse of CHIP or CHIP Perinatal services by healthcare Providers, other Members or health plans.

9. Talk to your child’s Provider about all of your child’s medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1.800.368.1019. You also can view information concerning the HHS Office of Civil Rights online at http://www.hhs.gov/ocr.

**Billing Members**

HHSC rules prohibit providers from balance billing CHIP Members (See 1TAC §§370.451 and 370.453). Specifically, HHSC rules require providers of services to CHIP Members to accept payment received for covered services as payment in full, and prohibits Providers from billing CHIP Members or their guardians for any remaining balances for covered services rendered. HHSC balance billing rules apply to network providers and non-network providers of authorized services.

Providers may only charge CHIP Members the copayment amounts authorized.

Providers are responsible for collecting all CHIP Member co-payments at the time of service.

Co-payments that families must pay vary according to their income level. Except for costs associated with unauthorized nonemergency services provided to a Member by out-of-network Providers and for non-covered services, the co-payments outlined in the CHIP cost sharing table in the HHSC Uniform Managed Care Manual are the only amounts that a Provider may collect from a CHIP-eligible family. No co-payments apply, at any income level, to CHIP Members who are Native Americans or Alaskan Natives, Additionally, for CHIP Members there is no cost-sharing on benefits for Well-Child or Well-Baby visits or immunizations, preventative services, pregnancy-related services.

The CHIP Member will not be responsible for any payment for medically necessary covered services, other than HHSC-specified co-payments for CHIP Members, where applicable.

**CHIP Member Cost-Sharing Schedule**

The table on the following page lists the co-pay schedule according to family income. Co-payments for medical services or prescription drugs are paid to the healthcare Provider at the time of service. No co-payments are paid for preventive care such as Well-Child or Well-Baby visits or immunizations. No copayments are paid for any pregnancy-related services.
## CHIP Cost-Sharing

### Twelve-Month Enrollment Fees:

<table>
<thead>
<tr>
<th>Enrollment Level</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 151% of FPL</td>
<td>$0</td>
</tr>
<tr>
<td>Above 151% up to and including 186% of FPL</td>
<td>$35</td>
</tr>
<tr>
<td>Above 186% up to and including 201% of FPL</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Co-Pays (per visit):

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 100% of FPL</td>
<td></td>
</tr>
<tr>
<td>Office Visit **</td>
<td>$3</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$3</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$3</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient</td>
<td>$15</td>
</tr>
<tr>
<td>Cost-Sharing Cap</td>
<td>5% (of family’s income)***</td>
</tr>
<tr>
<td>Above 100% up to and including 151% FPL</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$5</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$5</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$5</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$35</td>
</tr>
<tr>
<td>Cost-Sharing Cap</td>
<td>5% (of family’s income)***</td>
</tr>
<tr>
<td>Above 151% up to and including 186% FPL</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$20</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$35</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$75</td>
</tr>
<tr>
<td>Cost-Sharing Cap</td>
<td>5% (of family’s income)***</td>
</tr>
<tr>
<td>Above 186% up to and including 201% FPL</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$35</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$125</td>
</tr>
<tr>
<td>Cost-Sharing Cap</td>
<td>5% (of family’s income)***</td>
</tr>
</tbody>
</table>

Charges Effective January 1, 2014

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

**Effective March 1, 2012, CHIP Members will be required to pay an office visit copayment for each non-preventive dental visit.

***Per 12-month term of coverage.

### Member’s Right to Designate An OB/GYN (APPLIES TO CHIP ONLY)

Community allows the Member to pick an OB/GYN but this doctor must be in the same network as the Member’s Primary Care Provider.
ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to specialist doctor within the network

Community has a limited Provider network within its service area for the CHIP program. OB/GYN selection is limited to the PCP’s network if the Member selects a PCP in a limited Provider network. CHIP Members who do not select a limited Provider network PCP DO NOT have access to limited Provider network specialists.

Reporting Provider or Recipient Waste, Abuse or Fraud by A Provider or Client

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

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

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

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

- Call the OIG Hotline at 1.800.436.6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:

  Community Health Choice
  V.P. Compliance & Privacy
  2636 South Loop West, Ste. 125
  Houston, TX 77054
  1.877.888.0002

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

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

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

When reporting about someone who gets benefits, include:

- The person’s name
• The person’s date of birth, Social Security Number, or case number if you have it
• The city where the person lives
• Specific details about the waste, abuse, or fraud

CHIP Member Enrollment and Disenrollment from Community

Enrollment/Re-Enrollment
Children who enroll in CHIP receive 12 months continuous coverage. Families must re-enroll their children annually.

Eligibility for enrollment in CHIP is determined by the HHSC’s Administrative Services Contractor.

When Does an Enrolled Child Become Covered?
Enrollment in CHIP will begin on the first day of the month after eligibility is determined. A child may be subject to a waiting period if the coverage lapses or if the child is moving from private insurance to CHIP coverage.

Paying for Enrolled Child’s Coverage
If payment of an enrollment fee is required for the child’s CHIP coverage, the fee must be paid before the child can be enrolled in CHIP. Enrollment fees are the responsibility of the Member. Enrollment fees should never be sent to Community, but directly to the state’s enrollment broker.

Disenrollment
Disenrollment Due to Loss of CHIP Eligibility
Disenrollment may occur if a Member loses CHIP eligibility. A CHIP Member may lose CHIP eligibility for the following reasons:

• “Aging-out” when Member turns 19
• Failure to re-enroll by the end of the 12-month coverage period
• Change in health insurance status, i.e., a Member enrolls in an employer-sponsored health plan
• Death of a Member
• Member permanently moves out of the state
• Member is enrolled in Medicaid
• Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10 percent or more of the family’s gross income
• Child’s parent or authorized representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
• Child’s parent or authorized representative requests (in writing) the voluntary disenrollment of a child

Disenrollment by Community
Your child may be dis-enrolled by US, subject to approval by the HHSC, for the following reasons:

• Fraud or intentional material misrepresentation made by a Member after 15 days written notice;
• Fraud in the use of services or facilities after 15 days written notice;
• Misconduct that is detrimental to safe plan operations and the delivery of services;
• Failure to establish a satisfactory patient physician/Provider relationship so long as we have, in good faith, provided the Member the opportunity to select an alternative participating physician or Provider. We will notify the Member in writing 30 days in advance that we consider the patient-physician/Provider relationship to be unsatisfactory and will specify the changes that are necessary to avoid disenrollment. If such changes are not made, coverage may be cancelled at the end of 30 days;
• Child no longer lives or resides in the service area.
Community must notify the Member of Community’s decision to disenroll the Member if all reasonable measures have failed to remedy the situation.

If the Member disagrees with the decision to disenroll the Member from Community, Community must notify the Member of the availability of the complaint procedure.

Community will not disenroll a Member based on a change in the Member’s health status or because of the amount of medically necessary services that are used to treat the Member’s condition.

Providers may not take retaliatory action against Members.

Health Plan Changes

Members are allowed to make health plan changes under the following circumstances:

• For any reason within 90 days of enrollment in CHIP;
• If the Member moves to a different service delivery area;
• For cause at any time; and
• During the annual re-enrollment period. HHSC will make the final decision.
CHIP Perinatal Program

Program Objectives

CHIP Perinatal is designed for pregnant women who are under 200% of the FPL and cannot qualify for Medicaid due to income or resident status. This program was authorized by the Texas Legislature as an extension of the CHIP Program for women who cannot qualify for Medicaid, traditionally served by Title V Program. There are two groups:

- Below 185% of FPL
- 186% - 200% of FPL

The objectives of the program include:

- Expedite enrollment to improve prenatal care and pregnancy outcomes
- Extending CHIP services to unborn children of non-Medicaid eligible women to enroll the unborn child in CHIP for 186% - 200% FPL

How the Program Works

The expectant mother will enroll by completing an application or by calling 2-1-1 for assistance. The mother will be determined eligible, and the 12 months of continuous coverage will begin based on her effective date. Coverage for the expectant mother is limited to prenatal care benefits, including up to 20 prenatal visits, physician services, laboratory and radiological services, and prescription drugs.

For mothers below 185% of FPL, hospital/facility charges related to labor with delivery will be covered by Texas Emergency Medicaid. Community will be responsible for professional fees for the mother only. For mothers between 186% - 200% of FPL, hospital/facility charges related to labor with delivery and professional fees will be paid by Community. All payments are subject to Community’s utilization review requirements and contract requirements.

For Newborns 186 - 200% FPL: Upon birth, the child receives full CHIP benefits for the remainder of the 12-month eligibility period. Community is responsible for all professional and facility fees for the birth and any subsequent admissions while enrolled with Community. The child receives a Primary Care Provider (PCP) to provide all primary care services and to arrange for and coordinate referrals for all medically-necessary specialty services. The child receives all the same benefits as outlined in the Children’s Health Insurance Program for the duration of the CHIP Perinatal eligibility. Please refer to the CHIP section of this manual for more information about CHIP benefits.

Enrollees in the CHIP Perinatal Program are exempt from all enrollment fees, waiting periods, and cost sharing.

CHIP Perinatal Covered Services

Covered CHIP Perinatal services must meet the definition of Medically Necessary Covered Services as defined by the Health and Human Services Commission. There is no lifetime maximum of benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members. There is no spell-of-illness limitation for CHIP Perinatal Newborns.
<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient General Acute Services include:</strong></td>
<td>For CHIP Perinates in families with incomes at or below 185% 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 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.</td>
<td>None</td>
</tr>
<tr>
<td>• Covered medically necessary Hospital-provided services Operating, recovery and other treatment rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia and administration (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- dilation and curettage (D&amp;C) procedures,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- appropriate provider-administered medications, ultrasounds, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- histological examination of tissue samples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center**  
Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:  
- X-ray, imaging, and radiological tests (technical component)  
- Laboratory and pathology services (technical component)  
- Machine diagnostic tests  
- Drugs, medications and biologicals that are medically necessary prescription and injection drugs  
Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
- dilation and curettage (D&C) procedures,  
- appropriate provider-administered medications, ultrasounds, and  
- histological examination of tissue samples. | Requires prior authorization and physician prescription  
Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinatal 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, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.  
Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urine analysis 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 medical condition of client.  
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. | None |
<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Physician Extender Professional Services include, but are not limited to the following:</td>
<td>Does not require authorization for specialty services for use of contracted providers. Requires authorization for use of out-of-network providers.</td>
<td>None</td>
</tr>
<tr>
<td>• Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>• Physician office visits, in-patient and outpatient services</td>
<td>Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.</td>
<td></td>
</tr>
<tr>
<td>• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medically necessary medications, biologicals and materials administered in Physician’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Professional component (in/outpatient) of surgical services, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Administration of anesthesia by Physician (other than surgeon) or CRNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital-based Physician services (including Physician- performed technical and interpretive components)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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&amp;C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Prenatal care and pre-pregnancy family services and supplies</td>
<td>Does not require authorization for specialty services for use of contracted providers. Requires authorization for use of out-of-network providers. 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) and 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).</td>
<td>None</td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</strong>&lt;br&gt;Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery.&lt;br&gt;Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth.&lt;br&gt;• Emergency services based on prudent layperson definition of emergency health condition&lt;br&gt;• Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.&lt;br&gt;• Stabilization services related to the labor and delivery of the covered unborn child.&lt;br&gt;• Emergency ground, air and water transportation for labor and threatened labor is a covered benefit.&lt;br&gt;Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)&lt;br&gt;Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Case Management Services</strong>&lt;br&gt;Case management services are a covered benefit for the Unborn Child.</td>
<td>These covered services include outreach informing, case management, care coordination and community referral.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Care Coordination Services</strong>&lt;br&gt;Care coordination services are a covered benefit for the Unborn Child.</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

**CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinates**

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a.) miscarriage and (b.) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based health care services
- Nursing care services
• Dental services
• Inpatient substance abuse treatment services and residential substance abuse treatment services
• Outpatient substance abuse treatment services
• Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
• Hospice care
• Skilled nursing facility and rehabilitation hospital services
• Emergency services other than those directly related to the delivery of the covered unborn child
• Transplant services
• Tobacco Cessation Programs
• Chiropractic services
• Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child
• Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or postpartum care
• Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community
• 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
• Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
• 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 and 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 the Health Plan except for emergency care related to the labor and 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 (routine foot care does not include treatment injury or complications of diabetes)
• Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
• 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 that 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

Behavioral Health
Expectant mothers enrolled in CHIP Perinatal are not entitled to behavioral health services. Please refer to the CHIP portion of this manual for information on behavioral health benefits for CHIP Perinatal newborns.

CHIP Perinatal Program Covered Services for CHIP Perinate Newborns 186% to 200% FPL

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient General Acute and Inpatient Rehabilitation Hospital Services include:</strong></td>
<td>• Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition.</td>
<td>None</td>
</tr>
<tr>
<td>• Hospital-provided Physician or Provider services</td>
<td>• 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 caesarian section.</td>
<td></td>
</tr>
<tr>
<td>• Semi-private room and board (or private if medically necessary as certified by attending)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General nursing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Special duty nursing when medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ICU and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient meals and special diets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Operating, recovery and other treatment rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anesthesia and administration (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings, trays, casts, splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drugs, medications and biologicals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood or blood products that are not provided free-of-charge to the patient and their administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• X-rays, imaging and other radiological tests (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory and pathology services (facility technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Machine diagnostic tests (EEGs, EKGs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oxygen services and inhalation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Service</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Radiation and chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 caesarian section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital, physician and related medical services, such as anesthesia, associated with dental care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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&amp;C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other artificial aids including surgical implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Service</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</td>
<td>• Requires authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>Services include, but are not limited to, the following:</td>
<td>• 60 days per 12-month period limit</td>
<td></td>
</tr>
<tr>
<td>• Semi-private room and board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regular nursing services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rehabilitation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical supplies and use of appliances and equipment furnished by the facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</td>
<td>May Require prior authorization, as indicated below, and physician prescription.</td>
<td>None for preventive service</td>
</tr>
<tr>
<td>Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</td>
<td>• X-ray, imaging, and radiological tests (technical component) - may require prior authorization</td>
<td></td>
</tr>
<tr>
<td>• X-ray, imaging, and radiological tests (technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory and pathology services (technical component)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Machine diagnostic tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulatory surgical facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drugs, medications and biologicals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Casts, splints, dressings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical, occupational and speech therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Renal dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respiratory services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Radiation and chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood or blood products that are not provided free-of-charge to the patient and the administration of these products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• dilation and curettage (D&amp;C) procedures;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• appropriate provider-administered medications;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Co-Payed Co-payments

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ultrasounds; and</td>
<td>• May require prior authorization for nonemergency services.</td>
<td>- ultrasounds; and</td>
</tr>
<tr>
<td>- histological examination of tissue samples.</td>
<td>• Does not require PCP referral.</td>
<td>- histological examination of tissue samples.</td>
</tr>
<tr>
<td>• 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:</td>
<td>When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td>• 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: may require prior authorization</td>
</tr>
<tr>
<td>- cleft lip and/or palate; or severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td>• Does not require PCP referral.</td>
<td>- cleft lip and/or palate; or severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
</tr>
<tr>
<td>• Surgical implants</td>
<td>- ultrasounds; and</td>
<td>- surgical implants</td>
</tr>
<tr>
<td>• Other artificial aids including surgical implants</td>
<td>• histological examination of tissue samples.</td>
<td>- surgical implants</td>
</tr>
<tr>
<td>• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
<td>• 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: may require prior authorization</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td>- cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</td>
<td>• Surgical implants - may require prior authorization</td>
<td>• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</td>
</tr>
</tbody>
</table>

- dilation and curettage (D&C) procedures;
- appropriate provider-administered medications;
- ultrasounds; and
- histological examination of tissue samples.

| 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: |

- Dilatation 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: may require prior authorization
- Cleft lip and/or palate; or
- Severe traumatic, skeletal and/or congenital craniofacial deviations; or
- Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

- Surgical implants - may require prior authorization

- Other artificial aids including surgical implants - may require prior authorization.
### Covered Service

<table>
<thead>
<tr>
<th>Physician/Physician Extender Professional Services include, but are not limited to the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</td>
</tr>
<tr>
<td>• Physician office visits, in-patient and outpatient services</td>
</tr>
<tr>
<td>• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
</tr>
<tr>
<td>• Medications, biologicals and materials administered in Physician’s office</td>
</tr>
<tr>
<td>• Allergy testing, serum and injections</td>
</tr>
<tr>
<td>• Professional component (in/outpatient) of surgical services, including:</td>
</tr>
<tr>
<td>- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</td>
</tr>
<tr>
<td>- Administration of anesthesia by Physician (other than surgeon) or CRNA</td>
</tr>
<tr>
<td>- Second surgical opinions</td>
</tr>
<tr>
<td>- Same-day surgery performed in a Hospital without an over-night stay</td>
</tr>
<tr>
<td>- Invasive diagnostic procedures such as endo-scopic examinations</td>
</tr>
<tr>
<td>• Hospital-based Physician services (including Physician-performed technical and interpretive components)</td>
</tr>
<tr>
<td>• Physician and professional services for a mastec-</td>
</tr>
</tbody>
</table>

### Limitations

- Requires prior authorization for specialty services as indicated below:
  - American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) – Does not require prior authorization
  - Physician office visits, in-patient and outpatient services – Does not require prior authorization
  - Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation – Does not require prior authorization
  - Medications, biologicals and materials administered in Physician’s office
  - Allergy testing, serum and injections – may require prior authorization
  - Professional component (in/outpatient) of surgical services, including the following, may require prior authorization:
    - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
    - Administration of anesthesia by Physician (other than surgeon) or CRNA

### Co-Payments

- Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - does not require prior authorization
  - 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
Covered Service Limitations Co-Payments

- Second surgical opinions
- Same-day surgery performed in a Hospital without an over-night stay
- Invasive diagnostic procedures such as endoscopic examinations
- Hospital-based Physician services (including Physician-performed technical and interpretive components)
  - Does not require prior authorization
- Physician and professional services for a mastectomy and breast reconstruction include:
  - Does not require prior authorization
  - 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 caesarian 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.
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anoma-lies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  - cleft lip and/or palate; or
  - severe traumatic, skeletal and/or congenital craniofacial deviations; or
  - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
- 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 caesarean section – In network does not require prior authorization; out-of-network requires prior authorization
- Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. – requires prior authorization
- Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) may require prior authorization. Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: does not require prior authorization

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>tomy and breast reconstruction include:</td>
<td>- all stages of reconstruction on the affected breast;</td>
<td>- Second surgical opinions</td>
</tr>
<tr>
<td></td>
<td>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
<td>- Same-day surgery performed in a Hospital without an over-night stay</td>
</tr>
<tr>
<td></td>
<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td>- Invasive diagnostic procedures such as endoscopic examinations</td>
</tr>
<tr>
<td></td>
<td>- 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 caesarian section.</td>
<td>- Hospital-based Physician services (including Physician-performed technical and interpretive components)</td>
</tr>
<tr>
<td></td>
<td>Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</td>
<td>- Does not require prior authorization</td>
</tr>
</tbody>
</table>
| | Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) may require prior authorization. Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: | - Physician and professional services for a mastectomy and breast reconstruction include:
  - Does not require prior authorization
  - 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. |
<p>| | requires prior authorization | - 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 caesarean section – In network does not require prior authorization; out-of-network requires prior authorization |
| | Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. – requires prior authorization | - Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) may require prior authorization. Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: does not require prior authorization |</p>
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- dilation and curettage (D&amp;C) procedures;</td>
<td>- appropriate provider-administered medications;</td>
<td>- ultrasounds; and</td>
</tr>
<tr>
<td>- appropriate provider-administered medications;</td>
<td>- histological examination of tissue samples.</td>
<td>-</td>
</tr>
<tr>
<td>- ultrasounds; and</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>- histological examination of tissue samples.</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

- 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:

Requires prior authorization

- cleft lip and/or palate; or

- severe traumatic, skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Limitations</th>
<th>Co-Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</strong>&lt;br&gt; 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: &lt;br&gt; &lt;ul&gt;&lt;li&gt;Orthotic braces and orthotics&lt;/li&gt; &lt;li&gt;Dental Devices&lt;/li&gt; &lt;li&gt;Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses&lt;/li&gt; &lt;li&gt;Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease&lt;/li&gt; &lt;li&gt;Other artificial aids including surgical implants&lt;/li&gt; &lt;li&gt;Hearing aids&lt;/li&gt; &lt;li&gt;Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.&lt;/li&gt;&lt;/ul&gt; Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.</td>
<td>• May require prior authorization and physician prescription. &lt;br&gt; $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).</td>
<td>None</td>
</tr>
<tr>
<td><strong>Home and Community Health Services</strong>&lt;br&gt; Services that are provided in the home and community, including, but not limited to: &lt;br&gt; &lt;ul&gt;&lt;li&gt;Home infusion&lt;/li&gt; &lt;li&gt;Respiratory therapy&lt;/li&gt; &lt;li&gt;Visits for private duty nursing (R.N., L.V.N.)&lt;/li&gt; &lt;li&gt;Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).&lt;/li&gt; &lt;li&gt;Home health aide when included as part of a plan of care during a period that skilled visits have been approved.&lt;/li&gt;&lt;/ul&gt; Speech, physical and occupational therapies.</td>
<td>• Requires prior authorization and physician prescription. &lt;br&gt; • Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker. &lt;br&gt; • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. &lt;br&gt; Services are not intended to replace 24-hour inpatient or skilled nursing facility services</td>
<td>None</td>
</tr>
<tr>
<td>Covered Service</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Services</strong></td>
<td>Requires prior authorization for non-emergency services.</td>
<td>None</td>
</tr>
<tr>
<td>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including but not limited to:</td>
<td>Does not require PCP referral.</td>
<td></td>
</tr>
<tr>
<td>• Neuropsychological and psychological testing</td>
<td>When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Services</strong></td>
<td>• May require prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</td>
<td>• Does not require PCP referral.</td>
<td></td>
</tr>
<tr>
<td>• The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.</td>
<td>• 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 binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td></td>
</tr>
<tr>
<td>• Neuropsychological and psychological testing.</td>
<td>• A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25</td>
<td></td>
</tr>
<tr>
<td>• Medication management</td>
<td>• T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). 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 interventions such as day treatment and in-home services), patient and family education, and crisis services.</td>
<td></td>
</tr>
<tr>
<td>• Rehabilitative day treatments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Residential treatment services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills training (psycho-educational skill development)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Service</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Inpatient Substance Abuse Treatment Services</strong></td>
<td>• Requires prior authorization for non-emergency services.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Does not require PCP referral.</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient substance abuse treatment services include, but are not limited to:</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Treatment Services</strong></td>
<td>• Requires prior authorization.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Does not require PCP referral.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient substance abuse treatment services include, but are not limited to, the following:</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Intense outpatient services</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Partial hospitalization</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>• Requires prior authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Physical, occupational and speech therapy</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td>• Requires authorization and physician prescription.</td>
<td>None</td>
</tr>
<tr>
<td>Services include, but are not limited to:</td>
<td>• Services apply to the hospice diagnosis.</td>
<td>None</td>
</tr>
<tr>
<td>• 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</td>
<td>• Up to a maximum of 120 days with a 6-month life expectancy.</td>
<td>None</td>
</tr>
<tr>
<td>Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.</td>
<td>• Patients electing hospice services may cancel this election at any time.</td>
<td>None</td>
</tr>
<tr>
<td>Covered Service</td>
<td>Limitations</td>
<td>Co-Payments</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</strong></td>
<td>Requires authorization for post stabilization services.</td>
<td>None</td>
</tr>
<tr>
<td>Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency services based on prudent layperson definition of emergency health condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical screening examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stabilization services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency ground, air and water transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>Requires authorization.</td>
<td>None</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Using up-to-date FDA guidelines, all nonexperimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Benefit</strong></td>
<td>May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</td>
<td>None</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One pair of non-prosthetic eyewear per 12-month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health plan may reasonably limit the cost of the frames/lenses.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Service Limitations Co-Payments

#### Chiropractic Services
Covered services do not require physician prescription and are limited to spinal subluxation

- May require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit).
- May require authorization for additional visits.

**Co-Payments:** None

#### Tobacco Cessation Program
Covered up to $100 for a 12-month period limit for a plan approved program

- May require authorization.

Health Plan defines plan-approved program.

**Co-Payments:** None

---

**Note:** Spell of Illness Limitation Removed for CHIP Perinate Newborns

### CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinate Newborns

With the exception of the first bullet, all of the following exclusions match those found in the CHIP Program.

- For CHIP Perinate Newborns in families with incomes at or below 185% 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 birth
- 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
- Personal comfort items including, but not limited, to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- 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 supplied when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- 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 the Health Plan 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 the Health Plan

- 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)
- 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 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.) This exclusion does not apply to hospice services
- Housekeeping
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, 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

CHIP & CHIP Perinatal Program DME/Supplies

Note: DME/Supplies are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Covered</th>
<th>Excluded</th>
<th>Comments/Member Contract Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td></td>
<td>X</td>
<td>Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply not covered, unless RX provided at time of dispensing.</td>
</tr>
<tr>
<td>Alcohol, swabs (diabetic)</td>
<td></td>
<td>X</td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td>X</td>
<td></td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>Arm Sling</td>
<td></td>
<td>X</td>
<td>Dispensed as part of office visit.</td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Coverage</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td>✗</td>
<td>Over-the-counter supply.</td>
<td></td>
</tr>
<tr>
<td>Batteries – initial</td>
<td>✗</td>
<td>For covered DME items</td>
<td></td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td>✗</td>
<td>For covered DME when replacement is necessary due to normal use.</td>
<td></td>
</tr>
<tr>
<td>Betadine</td>
<td>✗</td>
<td>See IV therapy supplies.</td>
<td></td>
</tr>
<tr>
<td>Books</td>
<td>✗</td>
<td>For monitoring of diabetes.</td>
<td></td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td></td>
<td>See Ostomy Supplies.</td>
<td></td>
</tr>
<tr>
<td>Communication Devices</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td>✗</td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
<td></td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td>✗</td>
<td>Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>✗</td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
<td></td>
</tr>
<tr>
<td>Diapers/Incontinent Briefs/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chux</td>
<td>✗</td>
<td>Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>✗</td>
<td>Contraceptives are not covered under the plan.</td>
<td></td>
</tr>
<tr>
<td>Diastix</td>
<td>✗</td>
<td>For monitoring diabetes.</td>
<td></td>
</tr>
<tr>
<td>Diet, Special</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>✗</td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times, these items are dispensed in a kit when includes all necessary items for one dressing site change.</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>✗</td>
<td>Eligible for coverage only if receiving covered home care for wound care.</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral IV Therapy</td>
<td>✗</td>
<td>Eligible for coverage only if receiving home IV therapy.</td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Molds</td>
<td>✗</td>
<td>Custom made, post inner or middle ear surgery</td>
<td></td>
</tr>
<tr>
<td>Electrodes</td>
<td>✗</td>
<td>Eligible for coverage when used with a covered DME.</td>
<td></td>
</tr>
<tr>
<td>Enema Supplies</td>
<td>✗</td>
<td>Over-the-counter supply.</td>
<td></td>
</tr>
<tr>
<td>Enteral Nutrition Supplies</td>
<td>X</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Eye Patches</td>
<td>X</td>
<td>Covered for patients with amblyopia.</td>
<td></td>
</tr>
</tbody>
</table>
| 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 blenderized 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 parenterally. |
<p>| Gloves | X | Exception: Central line dressings or wound care provided by home care agency. |
| Hydrogen Peroxide | X | Over-the-counter supply. |
| Hygiene Items | X | Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan. |
| Incontinent Pads | X | Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item. |
| Insulin Pump (External) Supplies | X | Eligible for coverage when used during covered home care for wound care. |
| Irrigation Sets, Wound Care | X | |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td>Eligible for coverage for individual with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td>X</td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td>X</td>
<td>Eligible for individuals with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needles and Syringes/ Diabetic</td>
<td></td>
<td>See Diabetic Supplies and Needles and Syringes/Other</td>
</tr>
<tr>
<td>Central Line</td>
<td></td>
<td>See IV Therapy and Dressing Supplies/Central Line.</td>
</tr>
<tr>
<td>Needles and Syringes/ Other</td>
<td>X</td>
<td>Eligible for coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td>X</td>
<td>See Saline, Normal</td>
</tr>
<tr>
<td>Novopen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>X</td>
<td>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.</td>
</tr>
<tr>
<td>Parenteral Nutrition/ Supplies</td>
<td>X</td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td>X</td>
<td>Eligible for coverage:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) when used to dilute medications for nebulizer treatments;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) as part of covered home care for wound care; for indwelling urinary catheter irrigation.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stump Socks</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suction Catheters</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Tape</td>
<td></td>
<td>See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.</td>
</tr>
<tr>
<td>Tracheostomy Supplies</td>
<td>X</td>
<td>Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.</td>
</tr>
<tr>
<td>Under Pads</td>
<td></td>
<td>See Diapers/Incontinent Briefs/Chux.</td>
</tr>
<tr>
<td>Unna Boot</td>
<td>X</td>
<td>Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.</td>
</tr>
<tr>
<td>Urinary, External Catheter &amp; Supplies</td>
<td>X</td>
<td>Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan</td>
</tr>
<tr>
<td>Urinary, Indwelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter &amp; Supplies</td>
<td>X</td>
<td>Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Urinary, Intermittent</td>
<td>X</td>
<td>Cover supplies needed for intermittent or straight catherization.</td>
</tr>
<tr>
<td>Urine Test Kit</td>
<td>X</td>
<td>When determined to be medically necessary.</td>
</tr>
<tr>
<td>Urostomy supplies</td>
<td></td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Irrigation Sets, Wound Care</td>
<td>X</td>
<td>Eligible for coverage when used during covered home care for wound care.</td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td>Eligible for coverage for individual with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
</tbody>
</table>

### Coordination with Non-CHIP Covered Services

Community is not responsible for providing the services listed below, but is responsible for appropriate referrals for these services.

### Texas Agency Administered Programs and Case Management Services

Community will cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

Children who are served by TDFPS may transition into and out of Community more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the service area.

During the transition period and beyond, Providers must:

- Provide medical records to TDFPS
- Recognize suspected cases of abuse or neglect and appropriately refer to TDFPS
- Schedule medical and behavioral health services appointments within 14 days, unless requested earlier by TDFPS

### Essential Public Health Services

Community 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 in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations 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
- Referring to the local public health entity for TB contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact
- Referring for Women, Infant and Children (WIC) services
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- 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
- Referring lead screening tests to the TDSHS laboratory
CHIP Perinatal Complaints and Appeals

CHIP Perinatal Provider Complaints and Appeals

Key Terms to Understand

1. “Adverse determination” is a decision by the Community that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary or appropriate.

2. “Appeal” means the formal process by which Community addresses adverse determinations.

3. “CHIP or CHIP Perinatal Complaint“ is defined as any dissatisfaction, expressed by a complainant, orally or in writing to Community, with any aspect of the Community’s operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or dis-enrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

CHIP Perinatal Provider Complaints Process

A Provider may file a complaint at any time with Community. Send complaints to:

Community Health Choice
Attn: Service Improvement Team
2636 South Loop West, Ste. 125
Houston, TX 77054
Fax: 713.295.7033
Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Web site https://www.CommunityHealthChoice.org. Community shall acknowledge all written complaints within five business days. If a Provider’s complaint is oral, Community’s Acknowledgement Letter shall include a one-page Complaint Form.

Community shall acknowledge, investigate, and resolve all complaints not later than the 30th calendar day after the date Community receives the written complaint or one-page Complaint Form from the complainant.

CHIP Perinatal Provider Appeals Process

IMPORTANT REMINDER: NO APPEAL IS NECESSARY FOR CORRECTED CLAIMS, SUBMIT TO THE COMMUNITY CLAIMS ADDRESS.

Adverse Determination Definition

An Adverse Determination means that health care services provided or proposed to be provided are not medically necessary, not appropriate or experimental or investigational. This includes services provided and retrospective appeals.

Please note that an appeal to an Adverse Determination does not involve administrative denials, such as incorrect information on a claim (e.g., tax ID), timely filing or adjustments to paid claims. The following information will explain how to appeal an Adverse Determination.

Appeal of an Adverse Determination

A Provider may request an appeal of an adverse determination orally or in writing within 30 calendar days of the date on Community’s written notification of an adverse determination. Provider appeals must be in writing and accompanied by complete medical records. Appeals can be submitted through the Provider Portal on the Community Web site at https://www.CommunityHealthChoice.org. You may request your appeal verbally or in writing:
If an appeal is received without medical records, Community will send an Acknowledgement Letter requesting complete medical records. Medical records must be received within 10 calendar days from the date of the Acknowledgment Letter. If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing provider.

Community shall investigate and resolve all Provider appeals of Adverse Determinations not later than the 30th calendar day after the date Community receives the written appeal.

Because the appeal involves a question of medical necessity, Community will have a physician review the appeal. This physician will be someone who was not part of the original decision. An Appeal Resolution Letter will be sent to the patient/enrollee or a person acting on the patient/enrollee’s behalf and the provider. The letter will contain:

(A) a statement of the specific medical, dental, or contractual reasons for the resolution;
(B) the clinical basis for the decision;
(C) a description of or the source of the screening criteria that were utilized in making the determination;
(D) the professional specialty of the physician who made the determination;
(E) notice of the appealing party’s right to seek review by a Texas Department of Insurance approved Independent Review Organization (IRO).
(F) notice of the independent review process;
(G) a copy of a request for a review by an IRO form; and
(H) procedures for filing a complaint

If Community’s decision is upheld on appeal, a provider may request that the appeal be reviewed by a provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment at issue within 10 working days from the denial of the appeal. The provider must set forth in writing good cause for having a particular type of specialty provider review the services at issue. The review will be completed within 15 working days of receipt of the request. An Acknowledgement Letter will be sent within five (5) working days of receiving request of specialty review.

Denials of care for emergencies, life-threatening conditions, and denials of continued stays for hospitalized patients may be appealed as an expedited appeal.

**Expedited Appeals Procedures for Medical Necessity**

You have the right to ask for an expedited appeal for a denial of emergency care, life-threatening conditions or continued hospitalization. This type of appeal is when you feel your patient’s condition could get worse if you wait for the standard appeals process. You may request an expedited appeal, either orally or in writing. Because your appeal involves a question of medical necessity, Community will have a health care provider review the appeal. This health care provider will be someone who has not previously reviewed the case and is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

Community will provide the expedited appeal determination by telephone or electronic transmission and will send a letter within three working days of the initial notification. Community will respond to your expedited appeal based upon the medical or dental immediacy of the condition, procedure, or treatment under review, but the resolution of the appeal will not exceed 72 hours from the date all information necessary to complete the appeal is received by Community.

If Community upholds its original Adverse Determination, you may request a review from a TDI approved independent review organization (IRO). You may request a review by a specialist in the same or similar specialty, within ten (10) working days from the date of the last denial. You must state in writing good cause for having a particular type of provider review the case. The specialist review must be completed within fifteen (15) working days of receipt of the request.
You also have the right to file a complaint about this process. To file a complaint, please contact Community at:

Community Health Choice  
Attn: Service Improvement Team  
2636 South Loop West, Ste. 125   Houston, TX 77054  
Phone: 713.295.2294  
Toll-free: 1.888.760.2600

Community must resolve your complaint within thirty (30) days.

**Independent Review Organization (IRO)**

If the appeal of the Adverse Determination is denied, you have the right to request a review of an appeal by a Texas Department of Insurance approved Independent Review Organization (IRO). When Community denies the appeal, you will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process. The IRO will complete its review within 20 days of receipt of the request for IRO review. Requests for IRO review, including the IRO form (LHL009), should be submitted to:

Community Health Choice  
Attn: Appeals Department  
2636 South Loop West, Ste. 125  
Houston, TX 77054  
Phone: 713.295.2294  
Toll-free: 1.888.760.2600  
Fax: 713.295.7033

In circumstances involving a life-threatening condition, you are entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determination. In life-threatening situations, you may contact Community by telephone to request the review by the IRO and Community will provide the required information. The IRO will respond with a determination for reviews of life-threatening conditions within four (4) days of their receipt of the IRO request for expedited review.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review. Provider Complaints and Appeals Process to TDI

A Provider has the right to file a complaint over an appeal with the TDI. Send Provider complaints and appeals to:

Texas Department of Insurance  
P.O. Box 149091  
Austin, TX 78714-9091  
Toll-free: 1.512.463.6500 or 1.800.252.3439  
Fax: 512.475.1771  
Web site: http://www.tdi.state.tx.us

**CHIP Perinatal Member Complaints and Appeals**

**Member Complaints Process**

**How to file a complaint**

Members, or their authorized representatives, may file an oral or written complaint with Community and with TDI.

Members may make complaints to Community in writing, sent to the following address:

Community Health Choice  
Service Improvement Team  
2636 South Loop West, Ste. 125  
Houston, TX 77054
Or by calling Community toll-free at 1.888.760.2600.

Members should provide as much detail as possible describing their complaint. If Providers are involved, the name(s) of each Provider and, if services are involved, a description of the services and the date(s) of service. If the complaint is given orally, Community will mail a one-page Complaint Form to the Member. The Member should complete and return the Complaint Form to Community as soon as possible for prompt resolution.

**Can someone from Community help my Member file a complaint?**

If a Community Member needs assistance filing a complaint, they may call Community Member Services at 713.295.2294 or 1.888.760.2600 and a Community Member Advocate will assist them.

**Requirements and Timeframes for Filing a Complaint**

Community will, no later than the fifth business day after the date of the receipt of the complaint, send to the Member a letter acknowledging the date the complaint was received. If the complaint was received orally, Community will include a one-page Complaint Form stating that the Complaint Form should be returned to Community for prompt resolution.

After Community receives the complaint, Community will investigate and send Member a Resolution Letter. The total time for acknowledging, investigating and resolving Member complaints will not exceed 30 calendar days after the date Community receives the Member complaint.

Member complaints concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of the Member complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Members may use the appeals process to resolve a dispute regarding the resolution of a Member complaint.

**Filing Complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints through Community’s complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091. Complaints to the Texas Department of Insurance may also be filed electronically at http://www.tdi.state.tx.us.

**Member Complaint Appeals to Community**

If the Member complaint is not resolved to the Member’s satisfaction, the Member has the right either to appear in person before a Complaint Appeal Panel where the Member normally receives health care services, unless another site is agreed to by the Member, or to address a written appeal to the Complaint Appeal Panel. Community will complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for complaint appeal.

Community will send an Acknowledgment Letter to Member not later than the fifth day after the date of receipt of the request of the complaint appeal.

Community will appoint members to the Complaint Appeal Panel, which will advise Community on the resolution of the dispute. The Complaint Appeal Panel will be composed of an equal number of Community staff, physicians or other Providers, and enrollees. A member of the Complaint Appeal Panel may not have been previously involved in the disputed decision.

Not later than the fifth business day before the scheduled meeting of the Complaint Appeal Panel, unless Member agrees otherwise, Community will provide to Member or Member’s designated representative:

- any documentation to be presented to the panel by Community's staff;
- the specialization of any physicians or Providers consulted during the investigation; and
• the name and affiliation of each of Community’s representatives on the panel.

Member, or Member’s designated representative if Member is a minor or disabled, are entitled to:

1. appear in person before the Complaint Appeal Panel;
2. present alternative expert testimony; and
3. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after Member’s request for appeal.

Due to the ongoing emergency or continued hospital stay, and at Member’s request, Community will provide, in lieu of a Complaint Appeal Panel, a review by a physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

**Standard Member Appeals Process**

How will I find out if services are denied?

Services that do not meet the criteria of medical necessity may be denied by Community. A denial of this type is called an “adverse determination.” An Adverse Determination is a written notice by Community to deny or limit authorization of a requested service, including the type or level of service; reduce, suspend, or terminate a previously authorized service; deny in whole or in part of payment for service; failure to provide services in a timely manner, the failure of an HMO to act within the timeframes set forth in this agreement and 42 C.F.R. §438.408(b); or for a resident of a rural area with only one HMO, the denial of a Medicaid Member’s request to obtain services outside the Network.

Community will notify the Provider and Member when it issues an Adverse Determination within three business days by letter to the Provider and Member. If a Member is hospitalized at the time of Adverse Determination, Community with notify the Provider by telephone or electronic transmission within one business day, followed by letter to the Member within three business days. If Community is denying post-stabilization care following an emergency, Community shall issue the Adverse Determination within one hour of the request.

What can I do if Community denies or limits my Member’s request for a Covered Service

A Member has the right to appeal any services that have been denied by Community that do not meet the criteria of medical necessity. A denial of this type is called an “adverse determination.”

An Appeal is considered a disagreement with an Adverse Determination.

A Member can request an appeal orally or in writing.

How will I find out if services are denied?

Community will notify the Provider and Member when it issues an Adverse Determination in accordance with the following timeframes: within one business day by telephone or electronic transmission to the Provider, if hospitalized at time of Adverse Determination, followed by letter to the Member within three business days or three business days to the Provider and Member if not hospitalized. If Community is denying post-stabilization care following an emergency, Community shall issue the Adverse Determination within one hour of the request.

How to File an Appeal

Members, or their authorized representative, have the right to file an oral or written appeal to a Notice of Action with Community. Submit appeals to:
If a Member files a written appeal, Community will send the appellate a written acknowledgement within five business days. If a Member files an oral appeal, Community will send a written acknowledgement and an Appeal Form within five business days. The appellate must return the Appeal Form to document the appeal in writing. If a Member or his/her representative requests an expedited resolution of an appeal, Community will follow the steps in the subsection “Expedited MCO Appeals.”

Members, or their representatives, should provide as much detail as possible describing their appeal. If Providers are involved, the name(s) of each Provider and if services are involved, a description of the services and the date(s) of service. Members must understand that if the appeal decision is adverse to the Member, the Member may be financially responsible for the services which were the subject of the appeal, including services furnished while the appeal is pending.

**Timeframe for Filing an Appeal**

Members must file a Request for Appeal within 30 calendar days from receipt of a Notice of an Action. To ensure continuation of currently authorized services, a Member must file an appeal on or before the later of: 1.) 10 calendar days following Community’s mailing and notice of the action; or 2.) the intended effective date of the proposed action.

**Timeframe for Resolution of an Appeal**

Community will resolve standard appeals within 30 calendar days from the date Community receives the appeal. This timeframe may be extended up to 14 calendar days if: 1.) the Member requests an extension; or 2.) Community advises the Member of a need for additional information and that extending the timeframe may be in the Member’s best interest. Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**Can someone from Community help me file an appeal?**

If a Member needs assistance filing an appeal, they may call Community Member Services at 713.295.2294 or 1.888.760.2600 and an appeals coordinator will assist them with the appeal.

**When can a Member request a State Fair Hearing?**

A member can request a State Fair Hearing after Community’s appeals process has been exhausted. You must follow the internal complaint and appeals process before requesting a Fair Hearing.

**Expedited Member MCO Appeal**

**Right to an Expedited Appeal**

A Member, or his/her representative, may request an expedited appeal, if he/she believes that the standard appeal process may seriously jeopardize the Member’s life or health.

**How to File an Expedited Appeal**

Expedited appeals may be requested verbally or in writing. To request an expedited appeal, a Member or his/her representative should send the appeal to the following:

**Community Health Choice**

**Appeals Department**

**2636 South Loop West, Ste. 125**

**Houston, TX 77054**

**Phone: 713.295.2295 or 1.888.760.2600**

**Fax: 713.295.7033**
Community will accept expedited appeals 24 hours a day, seven days a week. Requests for expedited appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal.

**Resolution Timeframe for an Expedited Appeal**

Community must complete its investigation and resolution of an appeal concerning an ongoing emergency or continued hospitalization:

1.) in accordance with the medical immediacy of the case; and
2.) not later than one business day after Community receives the request for the expedited appeal.

If the expedited appeal does not involve the above, Community will notify the Member of the outcome of the appeal within three business days. This timeframe may be extended up to 14 calendar days if:

1.) the Member requests an extension; or
2.) Community advises the Member of a need for additional information and that extending the timeframe may be in the Member’s best interest.

Community will provide written notice of the reason for a delay, if the Member had not requested the delay.

**What if Community denies the request for an Expedited Appeal?**

If Community determines that a Member’s appeal request does not follow the definition of expedited appeal, it will treat the appeal as a standard appeal. Community shall make a reasonable effort to notify the appellate that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

**Who can help me file an Expedited Appeal?**

For assistance with an appeal or expedited appeal, call Member Services toll-free 1.888.760.2600.

**External Review by Independent Review Organization**

An independent review organization (IRO) makes decisions on medical necessity and appropriateness of care. If the appeal of the Adverse Determination is denied, a Member, Member’s designated representative or Member’s Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When Community or Community's Utilization Review Agent deny the appeal, the Member, Member’s designated representative or Member’s Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a life-threatening condition, Member is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In life-threatening situations, Member, Member’s designated representative or Member’s Physician or Provider of record may contact Community or Community’s Utilization Review Agent by telephone to request the review by the IRO and Community or Community's Utilization Review Agent will provide the required information. Members may call Member Services and ask for an “Independent Review Organization Form” at 713.285.2294 or 1.888.760.2600.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review.

Community will immediately notify TDI of the request for IRO review. TDI will assign the case to an IRO within one business day. If the IRO requests any information, Community must provide the information to TDI within 3 business days. The IRO must reach a decision within 15 days, but no later than 20 days after the IRO receives the case from TDI. In cases involving life-threatening conditions, the IRO must reach a decision within 5 days, but no later than 8 days after the IRO receives the case from TDI.

When the IRO completes its review and issues its decision, Community will abide by the IRO’s decision. Community will pay for the IRO review.

An IRO review is not available if Community denies payment for a non-covered service, such as cosmetic surgery. IRO review is also not available if a Member has already received treatment and Community determined that the treatment was not medically necessary.
The appeal procedures described above do not prohibit Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if Member believes that the requirement of completing the appeal and review process places Member's health in serious jeopardy.
CHIP Perinatal Member Eligibility

Eligibility
An expectant mother enrolled in CHIP Perinatal receives limited prenatal care benefits and her coverage ends at the time of birth. Her unborn child receives 12 months of continuous coverage, starting on the effective date.

A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (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 mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered by Emergency Medicaid. Clients under Medicaid Eligibility Threshold 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.

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 Medicaid Eligibility Threshold and the birth is reported to HHSC’s enrollment broker.

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

Eligibility for CHIP and CHIP Perinatal enrollment is determined by HHSC’s Administrative Services Coordinator.

Verifying Eligibility
All Community Members are issued a Community Member ID Card. When verifying Member eligibility, ask for your patient’s Community CHIP Member ID Card. Make a copy of both sides of the card for the Member’s file. Before providing services, verify that you have received an authorization number for inpatient or outpatient services. Failure to obtain authorization may result in a denial by Community. To verify Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

• Community Online at www.CommunityHealthChoice.org. You will need to fill out the Community Secure Access Application to become an authorized user. Call Community Member Services to get more information.

• Community Member Services at 713.295.2294 or 1.888.760.2600. You can check eligibility and benefits. Expectant mothers enrolled in CHIP Perinatal will not be assigned a PCP.

• Providers can receive eligibility information by calling the CHIP/CHIP Perinatal Provider eligibility hotline Monday through Friday 8:00 a.m. to 5:00 p.m. (Central Time). The hotline number is 1.800.647.6558. Providers who call the hotline can speak with a customer service representative to confirm whether an expectant mother or newborn child is a currently enrolled CHIP Perinatal member, or receive an automated response if the Provider has a CHIP Perinatal member ID number.

Be sure to have the following information when you call or go to Community Online:

• Member’s name
• Member’s ID number
**Application Assistance**

Community offers personal assistance to Community Members wishing to enroll in Medicaid or CHIP at the end of their CHIP Perinatal enrollment. Keeping benefits going is vital, and the application process can be confusing. Community offers meetings and personal help at this difficult time.

If your Community Member needs assistance with the filing process, please have them call 713.295.2222 or 1.877.635.6736 and Community will tell the Member about meetings or will assist them over the phone. If the Member needs a Renewal Form, they should call the CHIP Help Line at 1.800.647.6558 or call Community Member Services to get one.
CHIP Perinate Member Rights and Responsibilities

References to “you” or “your” apply to the mother of the Perinate (Unborn Child)

**Member Rights**

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

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

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

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

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

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

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

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

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

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

11. You have the right to a fair and quick process for solving problems with the health plan and the plan’s doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

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

**Member Responsibilities**

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

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

2. You must become involved in the doctor’s decisions about your unborn child’s care.

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

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

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

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

7. Talk to your Provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human
Services (HHS) toll-free at 1.800.368.1019. You also can view information concerning the HHS Office of Civil Rights online at http://www.hhs.gov/ocr.

**Reporting Provider or Recipient Waste, Abuse or Fraud by A Provider or Client**

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

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

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

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

- Call the OIG Hotline at 1.800.436.6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:

  **Community Health Choice**
  V.P. Compliance & Privacy
  2636 South Loop West, Ste. 125
  Houston, TX 77054
  1.877.888.0002

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

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

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

When reporting about someone who gets benefits, include:

- The person’s name
- The person’s date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

**CHIP Perinatal Member Cost Sharing Schedule**

There is no cost sharing or enrollment fee for Members enrolled with CHIP Perinatal.
Billing Members

HHSC rules prohibit providers from balance billing CHIP Members (See 1TAC §§370.451 and 370.453). Specifically, HHSC rules require providers of services to CHIP Members to accept payment received for covered services as payment in full, and prohibits providers from billing CHIP Members or their guardians for any remaining balances for covered services rendered. HHSC balance billing rules apply to network providers and non-network providers of authorized services.

There are no Member co-payments for CHIP Perinatal enrollees. Except for costs associated with non-covered services, a Member should be held harmless from all collection efforts.

The CHIP Perinatal Member will not be responsible for any payment for medically necessary covered services covered under the CHIP Perinatal.

Member’s Right to Designate An OB/GYN

Community allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member’s Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to specialist doctor within the network

CHIP Member Enrollment and Dis-Enrollment from Community

Enrollment

Expectant mothers who enroll in CHIP Perinatal receive up to 12 months of continuous coverage, beginning on the effective date of her eligibility. Eligibility for enrollment in CHIP and Medicaid is determined by the Texas Health and Human Services Commission’s Administrative Services Contractor.

CHIP Perinatal Newborn Process

Families must apply for Medicaid or CHIP prior to the end of the 12 months to ensure continuous eligibility. 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 CHIP Member’s information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her sibling’s existing CHIP case.

Disenrollment

Disenrollment due to loss of CHIP Perinatal Eligibility

Dis-enrollment may occur if a Member loses CHIP Perinatal eligibility. A CHIP Perinatal Member will lose CHIP Perinatal eligibility for the following reasons:

- Change in health insurance status, i.e., a parent of a UNBORN CHILD enrolls in an employer-sponsored health plan;
- Miscarriage resulting in the termination of the pregnancy
- Death of a UNBORN CHILD;
- Mother of UNBORN CHILD permanently moves out of the State;
- Voluntary disenrollment (in writing) is requested by the Perinate mom or acting on behalf of the newborn.
Disenrollment by Community

Community has a limited right to request a Member be disenrolled from Community without the Member’s consent. HHSC must approve and Community request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Fraud or intentional material misrepresentation made by YOU after 15 days written notice.
- Fraud in the use of services or facilities after 15 days written notice.
- Misconduct that is detrimental to safe plan operations and the delivery of services.
- Mother of the UNBORN CHILD no longer lives or resides in the service area.
- Mother of UNBORN CHILD is disruptive, unruly, threatening or uncooperative to the extent the UNBORN CHILD’s membership seriously impairs Health Plan’s or Provider’s ability to provide services to the UNBORN CHILD or to obtain new Members, and the mother of the UNBORN CHILD’s behavior is not caused by a physical or behavioral health condition.
- Mother of the UNBORN CHILD steadfastly refuses to comply with Health Plan restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Health Plan to treat the underlying medical condition).

Community must notify the member of Community’s decision to disenroll the Member if all reasonable measures have failed to remedy the situation.

If the Member disagrees with the decision to disenroll the Member from Community, then Community must notify the Member of the availability of the complaints procedure.

Community cannot request a disenrollment based on adverse change in the Member’s health status or utilization of services that are medically necessary for treatment of a Member’s condition.

Community will not disenroll a Member based on a change in the Member’s health status or because of the amount of medically necessary services that are used to treat the Member’s condition.

HHSC will make the final decision regarding disenrollment of a Member from Community.

Providers may not take retaliatory action against Members.

Plan Changes

A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (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 mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered by Emergency Medicaid. Clients under Medicaid Eligibility Threshold 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.

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 Medicaid Eligibility Threshold and the birth is reported to HHSC’s enrollment broker.

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

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.

When a member of a household enrolls in CHIP Perinatal, 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 the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member’s enrollment period, or (2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.

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

- for any reason within 90 days of enrollment in CHIP Perinatal
- if the member moves into a different service delivery area; and
- for cause at any time.
NON-DISCRIMINATION STATEMENT

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Service Care Center at 1.855.315.5386.

You can file a grievance in person or by mail, fax or email:

Service Improvement Department
2636 South Loop West, Suite 125
Houston, Texas 77054

Phone: 713.295.6704
Email: ServiceImprovement@CommunityHealthChoice.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

For more information: 1.855.315.5386.

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Service Care Center at 1.855.315.5386.

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Service Care Center at 1.855.315.5386.