Community Health Choice

STAR+PLUS

September 2024

Nursing Facility Provider Manual

Provider Services Local: 713.295.2295

Toll Free: 1.888.760.2600

Website: Provider.CommunityHealthChoice.org

TEXAS Health and Human Services

TEXAS STAR+PLUS Your Health Plan ★ Your Choice

COMMUNITY HEALTH CHOICE

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Quick Reference Information

Provider Services	For general questions or to submit your updates: Phone: 713.295.2295 Toll Free: 1.888.760.2600 CommunityHealthChoice.org Email: ProviderWebInquiries@CommunityHealthChoice.org Or contact your Provider Engagement Representative.
Community Health Choice Website	CommunityHealthChoice.org https://provider.communityhealthchoice.org/ The site offers general information and various tools that are helpful to the Provider such as: • Prior Authorization Requirements • Provider Manual • Provider Directories • Provider Newsletters • Downloadable Forms
Member Services and Specialist Scheduling	Phone: 713.295.2294 Toll Free: 1888.760.2600 • Benefit Coverage and Eligibility Verification • Physician Information • Service Questions • Interpreter Services • Specialist Referral Assistance
Claims Inquiries or Adjudication	CommunityHealthChoice.org Phone: 713.295.2295 Toll Free: 1.888.760.2600 Community Health Choice will accommodate three claims per call. Unlimited inquiries on website
Utilization Management (Medical)	Phone: 713.295.2295 Fax: 713.295.2283
Utilization Management (Behavioral Health)	Phone: 1.877.343.3108 Fax: 713.576.0932 (inpatient) Fax: 713.576.0931 (outpatient) Fax: 713.848.6941 (inpatient discharge)
Care Management/Disease Management: Asthma, Diabetes, High-Risk Pregnancy, Congestive Heart Failure	Phone: 832.CHC.CARE (832.242.2273) Fax: 713.295.7028 or 1.844.247.4300 E-mail: CMCoordinators@CommunityHealthChoice.org

Case Management: Behavioral Health	Phone: 713.295.2295 Fax: 713.576.0933 E-mail: BHCasemanagementreferrals@CommunityHealthChoice.org
Report High Risk Pregnancy or Sick Newborn	Phone: 713.295.2303 Toll Free: 1.888.760.2600 Fax: 713.295.7028
Peer-to-Peer Discussions	Phone: 713.295.2319
Diabetic Supplies	Phone: 713.295.2221 Fax: 713.295.2283
Outpatient Perinatal Authorizations	Phone: 832.242.2273 Fax: 713.295.7016 or 1.844.247.4300
Mailed Claims	Community Health Choice Attn: Claims P.O. Box 981840 El Paso, TX 79998-1840
Refund Lockbox	Community Health Choice P.O. Box 4818 Houston, TX 77210-4818
Electronic Claims	Submit directly through Community Health Choice's online claims portal: CommunityHealthChoice.org > For Providers > Provider Tools > Claims Center Payer ID: 48145 • Change HealthCare Solutions, Inc. (formerly Emdeon/Relay Health): 1.877.469.3263 • Availity: 1.800.282.4548 • TMHP (STAR only) TMHP.com
Adverse Determination and Appeals (Medical)	Community Health Choice Attn: Medical Appeals 4888 Loop Central Dr. Houston, TX 77081 Fax: 713.295.7033 All appeals must be in writing and accompanied by medical records.
Adverse Determination and Appeals (Behavioral Health)	Community Health Choice Attn: Behavioral Health Appeals P.O. Box 1411 Houston, TX 77230 Fax: 713.576.0934 (Standard Appeal Requests) Fax: 713.576.0935 (Expedited Appeal Requests) All appeals must be in writing and accompanied by medical records.
Behavioral Health	Toll Free: 1.877.343.3108

Dental Services	**For STAR + PLUS Members 21 years of age and over (Value Added)** FCL Dental: 1.877.493.6282
Lab	Members can go to any of these preferred laboratories: • Clinical Pathology Laboratories, Inc. • LabCorp • Quest Diagnostics
Pharmacy	Navitus Health Solutions 1.877.908.6023 | Navitus.com
Vision Services	Envolve Vision **For STAR + PLUS Members** Customer Service (Member Eligibility and Claims Inquires): 844.686.4358 Network Management (Provider Participation): 1.800.531.2818
Early Childhood Intervention (ECI)	Toll Free: 1.877.787.8999
Non-Emergency Medical Transportation (NEMT)	**For STAR+PLUS Members** Access2Care: 844.572.8194 Members can schedule also schedule NEMT through the Access2Care (A2C) Member app. App available via app store.
Enrollment/Disenrollment Medicaid and CHIP	Toll Free: 1.800.252.8263 2-1-1 YourTexasBenefits.com
File a Complaint	Community Health Choice Attn: Service Improvement 4888 Loop Central Dr. Houston, TX 77081 Fax: 713.295.7036 (STAR)/ Fax: 713.295.7054 (CHIP) ServiceImprovement@CommunityHealthChoice.org
Health and Human Services Office of the Ombudsman	Toll Free: 1.866.566.8989

Introduction

About Community Health Choice

Community Health Choice is a non-profit Managed Care Organization (MCO) licensed by the Texas Department of Insurance (TDI). Through its network medical and behavioral health Providers and acute/pediatric/behavioral health hospitals, Community Health Choice serves over 380,000 Members with the following programs:

- Medicaid State of Texas Access Reform (STAR) Program for low-income children and pregnant women
- Children's Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR
- STAR+PLUS is a Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older.
- Marketplace plans for individuals, including subsidized plans for low-income families
- Medicare Advantage Dual Special Needs plan (HMO D-SNP) for people with both Medicare and Medicaid.
- Administrator for collaborative safety net projects such as the Delivery System Reform Incentive Payment (DSRIP) and Network Access Improvement Program (NAIP), among others

Community Health Choice holds Health Plan accreditation with URAC. As an affiliate of the Harris Health System, Community Health Choice is financially independent and does not receive financial support from Harris Health or from Harris County taxpayers.

This manual is intended for Providers who have a contract with and participate in Community Health Choice's programs. The Provider Manual includes, but is not limited to information about how to submit claims, obtain authorizations, and understand covered services.

Vision Statement

Our vision is a healthy life for every Texan.

Mission Statement

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

Values Statement

Our team members of Community Health Choice are trustworthy, caring individuals who work collaboratively with our Members, Providers, and community partners. We are courageous, creative, and responsive as we serve Members and the community.

STAR+PLUS Program

STAR+PLUS Program Objectives

The STAR+PLUS program is a Medicaid managed care program providing integrated acute and long-term services and supports in a Medicaid managed care environment for elderly and disabled adults (mainly Supplemental Security Income [SSI]-eligible Medicaid clients). The STAR+PLUS program also covers individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver program (acute care and behavioral health services only — long-term services and supports are provided by the Texas Health and Human Services Commission [HHSC]).

In addition to the objectives of the STAR program, the STAR+PLUS program aims to:

- Integrate acute and long-term services and supports.
- Coordinate Medicare services for clients who are dual-eligible

Nursing Facility Covered Services

Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through provider mailings, faxes, newsletters and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

Nursing Facility Unit Rate

The nursing facility unit rate includes the types of services included in the HHSC vendor payment rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing facility unit rates exclude nursing facility add-on services as described below.

Nursing Facility MCO Add-On Services

Ventilator care add-on service

To qualify for supplemental reimbursement, a nursing facility member must require artificial ventilation for at least six consecutive hours daily, and the use must be prescribed by a licensed physician.

Tracheostomy care add-on service

To qualify for supplemental reimbursement, a nursing facility member must be less than 22 years of age; require daily cleansing, dressing and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

PT, ST, OT add-on services

Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility members who are not eligible for Medicare or other insurance. The cost of therapy services for members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the member's clinical record.

Customized power wheelchair (CPWC)

To be eligible for a CPWC, a member must be:

- Medicaid eligible.
- Age 21 years or older.
- Residing in a licensed and certified NF that has a Medicaid contract with HHSC.
- Eligible for and receiving Medicaid services in an NF.
- Unable to ambulate independently more than 10 feet.
- Unable to use a manual wheelchair.
- Able to safely operate a power wheelchair.
- Able to use the requested equipment safely in the NF.
- Unable to be positioned in a standard power wheelchair.
- Undergoing a mobility status that would be compromised without the requested CPWC.
- Certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative communication device (ACD)

An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For NF add-on therapy services, Community Health Choice will accept claims received: 1) from the NF on behalf of employed or contracted therapists, and 2) directly from contracted therapists who are contracted with the Community Health Choice. All other NF add-on providers must contract directly with and directly bill Community Health Choice.

NF add-on providers (except NF add-on therapy services providers) must refer to the STAR+PLUS Provider Manual for information, including credentialing and recredentialing.

Emergency Pharmacy Services

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 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:

- "8" in Prior Authorization Type Code (Field 461-EU)
- "8Ø1" in Prior Authorization Number Submitted (Field 462-EV)
- "3" in Days' Supply (Field 4Ø5-D5, in the Claim segment of the billing transaction)
- The quantity submitted in Quantity Dispensed (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g., an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed].

Call 877-908-6023 for more information about the 72-hour emergency prescription supply policy.

Non-Emergency Transportation

The Nursing Facility (NF) is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the NF Unit Rate. Transports of NF Members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians' offices for recertification examinations for NF care are not reimbursable services by Community Health Choice.

Community Health Choice is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

Emergency Dental Services

Medicaid Emergency Dental Services:

Community Health Choice 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 covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- open or closed reduction of fracture of the maxilla or mandible;
- repair of laceration in or around oral cavity;
- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- incision and drainage of cellulitis;
- root canal therapy. Payment is subject to dental necessity review and pre- and post- operative x-rays are required; and
- extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:

Community Health Choice is not responsible for paying for routine dental services provided to Medicaid Members.

Community Health Choice is responsible, however, for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment And Other Products Normally Found In A Pharmacy

Community Health Choice reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the NF unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Annual Limit on Inpatient Services

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

Unlimited Prescriptions

All Community Health Choice STAR+PLUS Members receive unlimited, medically-necessary prescriptions.

Dual Eligible Members

Dual eligible members have both Medicare and Medicaid health insurance coverage. Medicare or the member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare coinsurance and deductibles for dual eligible members unless enrolled in Community Health Choice's Medicare Advantage Special Needs Plans (SNP), HMO D-SNP.

Community Health Choice HMO D-SNP will coordinate the payment of the Medicare Advantage cost sharing amounts for dual eligible members up to the Medicaid fee schedule. Under Community Health Choice HMO D-SNP, there is no copayment for services received at a skilled nursing facility. Community Health Choice HMO D-SNP will reimburse Long- Term Services and Supports (LTSS) covered under the STAR+PLUS program. Community Health Choice STAR+PLUS benefits will not change or reduce any Medicare benefits for which a member is eligible.

Members with traditional Medicare coverage may choose to use their existing Primary Care Providers (PCP). Dual eligible members do not have to select a separate PCP through Community Health Choice for their LTSS services. The Service Coordinator will communicate and coordinate services with the member's Medicare PCP to ensure continuity of care. Dual eligible members should notify their service coordinators that they have Medicare coverage and will provide the name of their chosen PCP.

Dual eligible members have identification cards that indicate Long-Term Care (LTC) services only, and must show their ID cards each time they receive Community Health Choice STAR+PLUS covered services. Dual eligibles enrolled in Community Health Choice HMO D-SNP must show their ID cards each time they receive physician or hospital services. Dual eligibles do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

For dual eligible members, claims will process according to the member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid. For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over the-counter medications), some products used in symptomatic relief of

cough and colds, limited home health supplies (LHHS) and some prescription vitamins and mineral products, which are identified on the HHS Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (Texas VDP) formulary. Please note:

- A member with a Medicare Advantage plan will not affect the coverage of wrap benefits.
- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be covered by Medicaid without a prescription).

Note: If a STAR+PLUS dual member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's ID card.

Key Information for Nursing Facility Providers

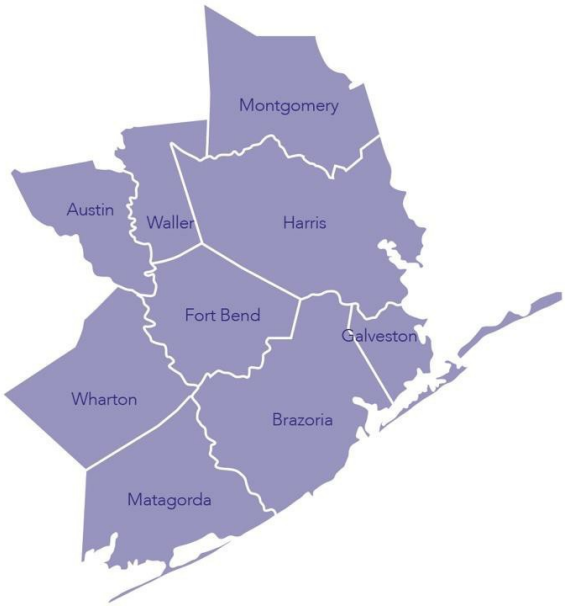
The following are some helpful tips for Nursing Facility providers:

- Verify member eligibility to ensure the first date of enrollment with the plan.
- Ensure necessary authorizations have been obtained from Community Health Choice for all add-on services.
- Use in-network providers for add-on services.
- Adhere to HHS clean claim rules, as found in the Community Health Choice Nursing Facility Provider Manual, Code of Federal Regulations, Title 42, §447.45(b).
- Notify the Service Coordinator whenever there is a change in the member's physical or mental condition, an inpatient admissions or an emergency room visit.
- Ensure that covered Medicare services are billed to Medicare as primary for members who are eligible for both Medicare and Medicaid.
- File claims for PASRR and hospice directly to the administrative services contractor for Medicaid fee-for-service.
- Continue submitting your MDS, 3618 and 3619 forms through the LTC online portal.

Community Health Choice Service Areas

Harris Service Area:

Austin, Brazoria, Fort Bend, Galveston, Harris,Matagorda, Montgomery, Waller, and Wharton Counties



Using the Provider Manual

The Provider Manual is designed as an informational and procedural guide for Community Health Choice Participating Providers and their staff. The manual contains instructions, quick reference guides, and Community Health Choice policies and procedures that will assist Providers and their staff's interaction with Community Health Choice. When utilized, this manual will decrease administrative burdens and improve overall Provider satisfaction:

- Researching details of STAR+PLUS program
- Obtaining prior authorizations for services
- Submitting corrected claims
- Appealing adverse determinations

Material in this Provider Manual is subject to change. The most recent information is also available on our website at CommunityHealthChoice.org. Updates and new services may be added periodically to the Provider Manual as required by law, rule or regulation. Community Health Choice 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 Texas Health and Human Services Commission (HHSC) policies and regulations, the Provider contract and HHSC policies and regulations shall govern. The Community Health Choice Provider Manual does not supersede or amend, in any manner, the contractual obligations of either Community Health Choice or the Provider to HHSC.

Providers may also reference the Texas Medicaid Provider Procedures Manual (TMPPM) online at TMHP.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx for additional resources, including the most current information about Texas Medicaid benefits, policies, procedures, and bulletins.

Code of Ethics

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

To achieve this goal, Community Health Choice Network Providers shall:

- Treat all Members with respect and courtesy
- Respond promptly to Members' questions and concerns
- 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 Health Choice 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
- Allow Community Health Choice to use their performance data
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.

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 Health Choice 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 website at CommunityHealthChoice.org.

Community's Commitment to Providers

Provider Credentialing and Recredentialing

As a Medicaid managed care organization, Community Health Choice must utilize the Texas Association of Health Plans' (TAHP) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations and primary source verification documents. At least once every three years, Community Health Choice must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the network.

Upon determination by Aperture (CVO) that your application is complete, the credentialing process can take up to 90 days.

If you are part of a group that already participates with Community Health Choice, you can request expedited credentialing, which will allow you to serve Medicaid recipients on a provisional basis while your credentialing application is pending. To qualify for expedited credentialing per Sec. 1452 of the Texas Insurance Code (TIC), you must meet all of the following criteria:

- Be a member of an established healthcare provider group that has a current contract in force with Community
- Be a provider type specified in TIC 1452
- Be licensed by the State of Texas, and in good standing with the appropriate state licensing Board
- Agree to comply with the terms of the contract
- Submit all documentation and information required to begin the credentialing process

Important: Please ensure that your credentials and information are current with CAQH to avoid any delays in the credentialing or recredentialing process.

CAQH: https://www.caqh.org/solutions/caqh-proview-providers-and-practice-managers

CAQH ProView

The Council for Affordable Quality Healthcare (CAQH) is a non-profit, mutual benefit corporation that has created a single system known as the CAQH ProView that meets the needs of nearly every health plan, hospital, and other healthcare organization. The CAQH ProView enables physicians and other healthcare professionals to enter information, free of charge, into a secure central database and then authorize healthcare organizations to access that information. The UPD eliminates redundant credentialing paperwork and reduces administrative burden. Community utilizes CAQH ProView for initial credentialing and recredentialing.

CAQH-Approved Provider Types

CAQH only accepts Provider data for the following approved list of Provider types:

- **Standard:** Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)
- **Allied:** Acupuncturist (ACU), Audiologist (AUD), Alcohol/Drug Counselor (ADC), Biofeedback Technician (BT), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Professional Counselor (PC), Licensed Practical Nurse (LPN), Massage Therapist (MT), Marriage/Family Therapist (MFT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optometrist (OD), Optician (OPT), Dietician (DT), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First

Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP), Pharmacist (PHA), Physician Assistant (PA), Physical Therapist (PT)

Note: It may be necessary for Community Health Choice to contact you to supplement, clarify or confirm certain information submitted on your CAQH application.

1. Community does not engage in any retaliatory action, including terminating or refusing to renew its Agreement with Provider, against Provider because Provider has, on behalf of a Member, reasonably filed a complaint against Community or appealed a decision of Community.

2. Community adjudicates (finalize as paid or denied adjudicated) Clean Claims for:
   - **a.** healthcare services within 30 days from the date the claim is received by Community;
   - **b.** pharmacy services no later than 18 days of receipt if submitted electronically, or 21 days of receipt if submitted non-electronically; and
   - **c.** pay Providers interest at a rate of 18% per annum on all clean claims that are not adjudicated within 30 days.

3. Community conducts new provider orientations within 30 days of the contract effective date or active status. Community offers training sessions via in-person, conference calls, Web-Ex, portal, and ad-hoc. The information includes, but is not limited to credentialing, appointment availability and access to care standards, utilization management, claims submission, appeals, complaints, covered services, THSteps services, and non-emergency medical transportation.

4. Community ensures that Members receive timely and appropriate access to all levels of care, emergent, urgent, routine, and preventive, within specifically defined timeframes.
   - **a.** PCPs within 10 miles or 15 minutes
   - **b.** OB/GYN within 30 miles or 45 minutes
   - **c.** Pre-natal care within 10 miles or 15 minutes
   - **d.** Outpatient Behavioral Health Service Providers within 30 miles or 45 minutes
   - **e.** Specialist Providers (cardiology/cardiovascular diseases, ophthalmology, and orthopedics/orthopedic surgery within 20 miles or 30 minutes; urology and psychiatry within 30 miles or 45 minutes; otolaryngology and all others not otherwise listed) within 30 miles or 45 minutes
   - **f.** Occupational and Speech Therapy (outpatient or clinical facility) within 30 miles or 45 minutes
   - **g.** Acute care hospital within 30 miles or 45 minutes
   - **h.** In urban counties, at least 80% of Members must have access to a network pharmacy within 2 miles of Members' residence
   - **i.** All other services: specialists not previously referenced, oncology including surgical and radiation, specialty hospitals, psychiatric hospitals, diagnostic services, and single or limited service healthcare physicians or Providers within 75 miles.

5. To ensure a quality network of Providers, Community credentials its Providers prior to making them available to its Members and prior to listing them in its Provider directories or other Member publications. Community's initial, re-credentialing, and continuous credentialing processes meet or exceed URAC and NCQA accreditation standards, as well as state and federal regulations.

   Community utilizes the Texas Association of Health Plan (TAHP) Credentialing Verification Organization (CVO), Aperture, for obtaining completed credentialing applications, attestations, and conducting primary source verifications as part of the initial credentialing and re-credentialing processes. The CVO conducts primary source verifications through the use of approved sources including, but not limited to, the American Medical Association or American Osteopathic Association for verification of education/training, the Texas Medical Board or other licensing agencies for verification of medical/professional licenses, the American Board of Medical Specialties for verification of Board Certification, the National Practitioner Data Bank for verification of any disciplinary actions and/or malpractice suits, and the OIG for verification of Medicaid/Medicare sanctions and/or exclusions. However, Community retains the sole responsibility for its credentialing program including established policies and procedures, and decisions pertaining to approval or denial of Providers applying for network participation. Community will submit credentialing documentation to the Texas Health and Human Services Commission (HHSC) as requested.

   To facilitate the efficient credentialing of physicians and other Provider types while ensuring delivery of quality care, Community may elect to delegate the credentialing process to groups of providers. Prior to delegating the credentialing

process, Community establishes clear guidelines that specifically outline the responsibility, accountability, and oversight of the delegated contractor and Community in order to maintain compliance with accreditation standards including NCQA, URAC, and other regulatory requirements.

Initial Credentialing

Acute care individual practitioner types credentialed include, but are not limited to, Medical Doctors (MD), Doctors of Osteopathy (DO), Dentists (DDS/DMD), Podiatrists (DPM), Physician Assistants (PA), Advanced Practice Registered Nurses (APRN), Therapists, Non-physician Behavioral Health Providers, and Long-Term Services and Support providers. Community requires individual practitioners interested in joining the network or applying for re-credentialing to complete the Texas Standardized Credentialing Application attesting to the following and verified via approved primary sources as applicable:

- Current and valid state professional license
- Current and valid DEA registration if applicable
- Board Certification if applicable
- Current professional liability insurance
- Malpractice claims history for the past 5 years
- Work history for the past 5 years (practitioners only)
- Hospital privileges, as applicable
- Ability to perform the functions of the position with or without accommodation
- History of loss of license and/or felony convictions
- Lack of present illegal drug use and a history of loss of limitation of privileges
- Lack of Medicare/Medicaid sanctions or other disciplinary activity
- Statement by Provider if accepting new Community Heath Choice patients

Institutional (facility) Providers are required to complete a common facility application generated and approved by the TAHP for use by health plans and the statewide CVO.

The Providers must attest to the accuracy of the information provided and authorize the CVO to conduct primary source verification, at minimum, of the following:

- Current and valid license to practice
- Current and valid DEA registration if applicable
- Accreditation or CMS Survey if not accredited
- Completion of site review by Community for non-accredited facilities
- Malpractice claims history for the past 5 years
- Current professional liability insurance
- Lack of Medicare/Medicaid sanctions or other disciplinary actions

Within 5 days of receipt of the credentialing application, Community notifies the Provider applicant of his or her rights in the credentialing process and of any missing information that may be required in order to proceed with the credentialing process. Providers are given a total of 30 days to submit the requested information. If items are not received within this timeframe, the application is considered withdrawn and is returned to the Provider directing them to reapply once all documentation is obtained.

Community does not deny credentialing because of gender, race, creed, color, national identity/ethnic origin, age, sexual orientation, or a disability that does not affect the applicant's ability to practice within his or her specialty. Additionally, Community will not discriminate against a Provider based upon the type of treatments in which the Provider specializes, the types of patients the Provider traditionally treats, reimbursement, or indemnification if the Provider is acting within the scope of a valid license and/or certification.

Upon completion of the primary source verification process, the CVO will submit completed files to Community for review by the Medical Care Management Committee (MCMC). This credentialing and peer review committee is chaired by Community's Chief Medical Director and is comprised of primary care and specialist physicians who are contracted and credentialed in Community's network. The MCMC meets on a monthly basis and makes the final decision regarding all Providers applying to the network. Community notifies Providers of the committee's decision within 10 business days and are loaded into the claims payment system no later than 90 days after receipt of the completed application.

Recredentialing

Community implements its policies and procedures for re-credentialing acute care physicians, individual practitioners, and institutional providers, at minimum, every three years in order to re-verify credentialing information and assess performance for the previous three-year period. Similar to the initial credentialing, this process also includes obtaining a signed and dated application and updating information obtained in the initial credentialing process.

6. Community ensures compliance with state and federal standards regarding authorizations for medical/acute services, mental health services, prescription drugs, and 72-hour emergency supplies.

7. Community provides 30 days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. However, in the case of suspected Fraud, Waste, or Abuse by a single Provider, Community may implement changes to policies and procedures affecting the prior authorization process without the required notice period.

8. Community provides notice to Providers regarding other measures as developed by HHSC or Community via methods including, but not limited to quarterly newsletters, fax blasts, and targeted communication.

Provider Responsibilities

Role of Nursing Facility

Nursing Facility providers provide institutional care to Medicaid recipients whose medical condition regularly requires skills of licensed nurses. Nursing homes provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies and equipment and personal needs items.

- Provide member access to 24-hour Nursing Facility (NF) Services
- Coordinate care with the member assigned Primary Care Provider and Nursing Facility staff
- Provide notice to Community Health Choice's designated Service Coordinator via phone, facsimile, email, or other electronic means no later than one business day after any one of the following events:
    - a significant, adverse change in the Member's physical or mental condition or environment that could potentially lead to hospitalization
    - an admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long term care facility
    - an emergency room visit
    - Nursing Facility initiates an involuntary discharge of a Member from a facility
- Provide services as needed as identified in the Minimum Data Set (MDS) based upon the NF plan of care
- Work in a collaborative effort with the Service Coordinator to meet the NF Member needs
- Provide/contract for STAR+PLUS Add-On Services and MMP services
- Provide member access to hospice services as needed
- To submit Form 3618 or Form 3619, as applicable, to HHS administrative services contractor.
- To submit Minimum Data Set (MDS) assessments, as required to federal Centers for Medicare and
- Medicaid Services (CMS) and associated MDS LongTerm Care Medicaid Information Section to HHS' administrative services contractor.
- To complete and submit Preadmission Screening and Resident Review (PASRR) Level I screening information to HHS' administrative services contractor
- Must coordinate with LAs and LMHAs to complete a PASRR Level 2 Evaluation when an individual has been identified through the PASRR level 1 screen as potentially eligible for PASRR specialized services
- For Members in a Nursing Facility, the right to designate a specialist as their PCP, as long as the specialist agrees
- To make reasonable efforts to collect applied income, document those efforts and notify the Service Coordinator or Community Health Choice designated representative when the provider has made two unsuccessful attempts to collect applied income in a month.

HHSC Form 3618

The Nursing Facility Provider must complete and submit Form 3618 to HHSC's administrative

services contractor.

Purpose

- To inform Texas Health and Human Services Commission (HHSC) staff about transactions and status changes for
- Medicaid applicants and recipients.
- To provide HHSC state office with information necessary to initiate, close or adjust vendor payments. These payments are made on behalf of eligible recipients in contracted Title XIX facilities.
- To provide data necessary for statistical reports.

Procedure

Form 3618, Resident Transaction Notice, can only be submitted electronically by completing Form 3618 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice.
- The nursing facility must print out and complete all items on Form 3618, including Item 13 with the nursing facility administrator's State Board license number, and have the nursing facility administrator sign and date Form 3618 for Item 14.

When to Prepare

The nursing facility administrator prepares Form 3618 for recipients who are:

- eligible Medicaid recipients,
- applicants for medical assistance, or
- Medicaid recipients who are being discharged from the Medicaid program.

The nursing facility administrator prepares a separate Form 3618 for each transaction. Each admission into or discharge from the facility requires a Form 3618 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618 or Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

- Form 3618 must be completed, and all copies submitted within 72 hours of the date of the transaction.
- Form 3618 is not used to report transactions involving private-pay residents, except when a resident who has been private pay is applying for Medicaid or when a recipient has been receiving Medicaid and is denied.

HHSC Form 3619

The Nursing Facility Provider must complete and submit Form 3619 to HHSC's administrative services contractor.

Purpose

- To inform Texas Health and Human Services Commission (HHSC) staff about transactions and status changes for Medicaid applicants and recipients.
- To provide HHSC state office with information necessary to initiate, close or adjust Medicare skilled coinsurance payments. These payments are made on behalf of eligible recipients in Medicare skilled nursing facilities.
- To provide data necessary for statistical reports.

Procedure

Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice, can only be submitted electronically by completing Form 3619 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice
- The nursing facility must print out and complete all items on Form 3619 including Item 14 with the nursing facility administrator's State Board license number and have the nursing facility administrator sign and date Form 3619 for Item 15.

When to Prepare

The nursing facility administrator prepares Form 3619 for recipients who are Medicaid recipients/applicants approved by Medicare for a Medicare skilled nursing facility (SNF) stay.

The nursing facility administrator prepares a separate Form 3619 for each transaction. Each admission into or discharge from the facility requires a Form 3619 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618, Resident Transaction Notice, and Form 3619, Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

- Form 3619 must be completed, and all copies submitted within 72 hours of the date of the transaction.
- Form 3619 is not used to report transactions involving private-pay residents.
- Access HSSC Forms and Instructions for complete submission instructions regarding Forms 3618 and 3619.

Role of a Primary Care Provider (Medical Home)

HHSC and DSHS encourage Providers participating in the STAR+PLUS Program to practice the "Medical Home" concept. To realize the maximum benefit of health care, 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 health care. 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 (PCPs) may include the following specialties:

- General Practitioners
- Family Practitioners
- Internists
- Pediatricians
- Obstetricians/Gynecologists (OB/GYN)
- Federally Qualified Health Centers (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 or behavioral needs)

If you are interested in learning more about Community Health Choice's Patient Centered Medical Home Program, please reach out to your Provider Engagement Representative for more information.

Role of Specialty Care Provider

The specialty care provider coordinates care with the member's PCP through the submission of consultation letters and recommendations for inclusion in the member's medical record. This includes the coordination, documentation and communication of all physical medicine and behavioral health care on behalf of members. Specialty care providers maintain regular hours of operation that are clearly defined and communicated to members and provide urgent specialty care appointments within 24 hours of request.

How to Contact a Service Coordinator

Please call Member Services at 713.295.2300 or 1.888.435.2850, TDD/TTY: 7-1-1 for deaf and hard of hearing or providers can call the Service Coordination Hotline at 713.295.5004 or 1.888.435.5150

Providers can also retrieve the members Service Coordinator information on the Community Health Choice Provider Portal.

Service Coordination Services

Service coordination is specialized care management services that are performed by a licensed, certified and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Engaging the member, the member's representative and caregivers in the design of the member's individual service plan (ISP)
- Arranging for delivery of the needed services and monitoring provision and timeliness
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services
- Making sure the member has a primary care provider

According to the Texas Health and Human Services Commission (HHSC) STAR+PLUS rate setting documentation for 2023, six percent of the 107,000 STAR+PLUS Members in the Harris Service Delivery Area are in a Nursing Facility. Based on internal population projections for Community's STAR+PLUS program beginning in 2024, this equates to approximately 500 Members being expected to reside in a Nursing Facility (based on six percent of an anticipated 8,000 Member STAR+PLUS population). Based on the projected population for Nursing Facility, Community dedicates a minimum of four (4) Level 1 Nursing Facility SCs with a case ratio not to exceed 1:130 Members.

Community ensures that each Nursing Facility is assigned a SC who serves as the named SC for all of Community's Members residing in that facility. In instances where more than 130 of Community's Members reside in a Nursing Facility, Community assigns an additional SC to that facility to account for caseloads exceeding NF SC case load ratios of 1:130. There are several key aspects and critical functions Community incorporates into Service Coordination processes related to Nursing Facility.

Identifying Community Based Members for Potential Nursing Facility Placement

A cornerstone of the STAR+PLUS program is ensuring Members have the opportunity to reside in a Community-based setting whenever possible. There are circumstances, however, where the appropriate level of care and setting for a Community STAR+PLUS Member is not in a home or Community-based setting (HCBS). In these instances, a Community HCBS Level 1 SC may be informed of a possible Nursing Facility placement. There are several ways this occurs. The Member or a Family Member (such as a legal guardian) may request a placement to a Nursing Facility. The HCBS Level 1 SC may recommend a placement based on the results of Member contact or assessments (such as the Comprehensive

Needs Assessment) that are conducted as part of ongoing service coordination and identify a potential need for placement in a Nursing Facility. When this occurs, the HCBS Level 1 SC discusses with the Member and/or Member's family preference for placement, provides available options within the Member's zip code or Pod service area, and refers the member to the selected Nursing Facility admission staff for potential placement. When this occurs, the HCBS Level 1 SC documents the referral in the clinical information management platform. Member's record as a referral activity, which triggers a potential reassignment to a NF Level 1 SC pending the results of the Preadmission Screening and Resident Review (PASRR) Level 1 (PL1) screening completed by the Nursing Facility.

HCBS Level 1 Members that are hospitalized and pending discharge may also be referred to a Nursing Facility as part of the Expected Hospital Discharge process. This process may occur when the Community Member's physician has certified that a person being discharged from an acute care hospital is likely to require less than 30 days of nursing facility (NF) services for the condition for which the person was hospitalized. If this occurs, Community Utilization Management Staff and the assigned HCBS Level 1 SC coordinate during the discharge planning process for the Community Member to ensure the physician provides the NF with a copy of the PL1. The NF enters the PL1 into the TMHP Long Term Care Online Portal (LTCOP) immediately upon the person's admission. Members with a positive PL1 screening will only require a PASSR evaluation (PE) if their stay exceeds 30 days in the Nursing Facility.

A person in this category with a positive PL1 will only require a PASRR evaluation (PE) if a stay in the NF exceeds 30 days.

In any situation where the PL1 is considered negative, the Member does not reside in the Nursing Facility and returns to the HCBS setting. Community's assigned HCBS Level 1 SC remains the SC for the Member. If the Member has a positive PL1, they are systematically assigned a NF Level 1 SC in the clinical information management platform.

Service Coordination for Members Residing in a Nursing Facility

As described above, STAR+PLUS Members may be referred to a Nursing Facility from a HCBS setting. Members already in a Nursing Facility may also select Community as their STAR+PLUS plan, or existing STAR+PLUS NF Members who elect not to select a STAR+PLUS plan may be enrolled into Community's STAR+PLUS plan as part of Texas HHSC' MCO assignment algorithms as part of its standard enrollment process. Regardless of the circumstances of how a Community Member's placement in a Nursing Facility occurs, the organization's Service Coordination processes for NF Level 1 Members ensures an effective approach to service coordination is in place for this medically fragile population.

Upon designation as a Nursing Facility resident in the state's 834 enrollment process, Community's medical management platform runs business rules to assign a Nursing facility's assigned Level 1 SC to the Member based on the Member's facility address. If this is not present on the 834 file, and the Service Coordination staff must confirm the location of the Nursing Facility the Member resides in, then the Service Coordination Manager manually assigns the Member to the appropriate NF Level 1 SC in the clinical information management platform. Once the appropriate SC is assigned, the clinical information management platform logic assigns him/her an initial outreach activity that must be completed within three business days. If unsuccessful, second and third attempts occur within one business day of each prior attempt (with attempts occurring at different times of the day). Staff follows the Unable to Contact process and subsequent Unscheduled Visit and Monitoring processes if contact attempts remain unsuccessful.

When the SC successfully contacts the Member, the Initial Outreach Activity status is changed to 'Successful Outcome' and an Initial Assessment Activity is systematically assigned to the SC and the assessment is scheduled not later than 14 calendar days from the date of Member enrollment with Community.

No less than 24 hours from the scheduled visit and assessment, the assigned SC completes the steps listed in the Nursing Facility Pre-Visit Checklist configured in the clinical information management platform. The following items are checked or completed prior to visit:

- Verify member is in NF
- Verify room number
- HIPAA verification
- Verify custodial vs skilled placement
- Minimum Data Set (MDS) data availability and review

During the completion of this checklist, the SC verifies if the Member is in a Custodial care status. If MDS data or other research shows that the level of care is at the Skilled Nursing level instead of Custodial, the SC assigns himself/herself an activity in the clinical information management platform to follow the Skilled Nursing in a NF Transition of Care process. This process will either result in a transition back to a community setting or result in a transition to Custodial care. Once the SC determines Custodial care status, a review of all available medical records, case notes, and claims data in the clinical information management platform and core claims system is conducted prior to the Nursing Facility visit. This allows the SC to have the most current 360-degree view of the Member's status prior to the visit.

Once the SC arrives to the Nursing Facility, he/she will verify any changes in Member condition, updated statuses, or discharges with appropriate NF staff (business office) and record pertinent information as a clinical note in the Member's the clinical information management platform record. If previously unavailable, the SC will obtain MDS access at the NF and review prior to meeting with his/her Member. If available, the PASRR evaluation and MDS (or MDS Summary) are loaded into the Member's the clinical information management platform record. After compiling, adding to the Member record, and reviewing available pertinent information, the SC visits with the Member and completes the appropriate comprehensive needs assessment. The clinical information management platform is configured with a Member Contact/Visit Script that is appropriate for Nursing Facility visits. The assessment confirms custodial status, identifies unmet needs, and informs the Member's service plan with evidenced based Opportunities, Goals, and Interventions (OGIs) sets that are systematically triggered as draft plans of care within the clinical information management platform service plan section. These OGIs may be reviewed, modified, and accepted by the Member through SC review. The service plan is then tailored to meet the Member's needs. The SC reviews any referrals based on assessment responses and clinical judgment and makes recommendations to the Member on available referrals for appropriate Behavioral Health (BH), Case Management (CM), or Disease Management (DM) programs that benefit the Member and may aid in reintegration into a community-based setting. As the service plan is reviewed and finalized by the Member with input and recommendations from the SC, the Member's interest in transitioning back into the Community is assessed during each Member visit in the Nursing Facility. If the Member desires to return to a community setting, the Money Follows the Person process is initiated as described in the subsection below. Once the service plan is updated, it is provided to the Member (either printed out on site, emailed, or mailed) for signature. The SC completes the Initial Assessment Activity with a status of 'Completed' which triggers a subsequent Quarterly Visit Activity assigned to the NF SC in the clinical information management platform to be completed no earlier than 60 calendar days and no later than 90 calendar days from the completed visit. The clinical information management platform will assign subsequent Quarterly Visit Activities each time a visit activity status is updated to 'Completed' as long as the Member resides in the Nursing Facility.

Transition from Nursing Facility to Community. As mentioned above, every visit with a NF Member includes assessing a Member's desire to transition to a Community-based setting. When the Member desires a placement in the Community, the Money Follows the Person (MFP) process is initiated. This is initiated in the clinical information management platform when the NF Level 1 SC is informed of the desire transition from the Member and he/she adds the Community MFP Coordinator to the Member Care Team tab in the clinical information management platform. At this point, the NF SC schedules an assessment appropriate to facilitate the MFP process begins the process:

- Complete Form H2067 to the STAR+PLUS Program Support Unit (PSU) via secure email to inform them of the Member's desire to leave the Nursing Facility

- Complete the H6516 Needs Assessment for Community First Choice (CFC) Services
- Complete the Medical Necessity Level of Care Assessment (MN/LOC) if the Member's Resource Utilization Group (RUG) obtained from the MDS is within 90 days of expiration
- Does not complete the MN/LOC and instead submits the RUG listed in the MDS if the RUG is 90 days or greater from expiration (along with the completed Needs Assessment)
- SC completes Form H2067 to the PSU if the MN/LOC is conducted

Once the appropriate assessment steps are completed, the NF SC assigns an activity to refer the Member to the Houston Center for Independent Living (HCIL) to completed via secure email. The HHSC STAR+PLUS PSU reviews the MFP request and documentation and returns a decision to the SC and Member through form H2065-D. If the Member is denied a transition to a HCBS setting, the decision is annotated in the clinical information management platform record and the Member remains in the NF setting. If the request to transition is approved, a RUG is provided by the PSU and added into the Member's the clinical information management platform record. The NF SC identifies the Member discharge from facility date, coordinates with the MFP Coordinator and HCIL, and self-schedules a visit activity at the Member's Community-based setting (i.e. home) on the day of NF discharge. The NF SC sends Form H2067 to the PSU to confirm the member relocation and marks the activity with a status of 'Transition Complete'. This activity status triggers an activity to the Service Coordination Manager to manually reassign the Member to a HCBS SC and the appropriate SC Change Letter is systematically generated and sent to the fulfillment center for mailing with five business days of reassignment. The HCBS SC is now responsible for the transitioned Member and after 30 calendar days of Member transition removes the MFP Coordinator from the member's Care Team tab in the clinical information management platform. He/she also self-assigns a Member Contact Activity (per the Member's Service Coordination Level) no than two months and no later than three months from the Member's NF discharge date to follow-up with the transitioned Member to ensure service in place meet the Member's needs. The Member is then managed according to his/her Service Coordination level.

Service Coordination for Level 1,2, and 3 Members

We provide a single, identified person as a service coordinator to all STAR+PLUS members who qualify as Level 1 or Level 2 under HHSC guidelines or when we determine one is required based on our assessment of the member's health and support needs. We will also provide a single, identified person with a service coordinator to all Level 3 members. Level 1 members include HCBS STAR+PLUS Waiver recipients, individuals with severe and persistent mental illness (SPMI), and other members with complex medical needs. Level 1 Members, or Members with SPMI, and all other level 1 Members not mentioned above will receive a minimum of two (2) face-to-face and four (4) telephonic Service Coordination contacts annually. Community will schedule a face-to-face visit outside of the four to six-month timeframe at the Member's request. Level 2 members include those members receiving LTSS for personal assistance services or day activity and health services (PAS and DAHS), members with non-SPMI behavioral health issues, Medicaid Breast Cancer and Cervical Program members, and Medicare and Medicaid dual-eligibles that do not qualify as Level 1. Level 2 Members will receive a minimum of one (1) face-to-face and one (1) telephonic Service Coordination contact annually. Members with non-SPMI BH issues and Medicaid for Breast and Cervical Cancer (MBCC) Members will also receive a minimum of one (1) face-to-face and one (1) telephonic Service Coordination contact annually. Level 3 members are those who don't qualify as Level 1 or Level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services; however, Community assigns all Level 3 Members with a single identified person as their assigned Service Coordinator. Level 3 Members will receive a minimum of two (2) telephonic contacts annually. All members within a nursing facility will be assigned the same service coordinator. Level 1 Nursing Facility (NF) Members receive quarterly face-to-face visits, including NF service planning meetings or other interdisciplinary team meetings. Quarterly face-to-face visits are scheduled at least 60 days apart, but no more than 90 days elapse between visits.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services. Service coordinators work with members and providers to coordinate all STAR+PLUS covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician, regardless of network status.

The SC actively works to establish relationships with others involved in the Member's support/care. The SC accomplishes this through establishing relationships with the Member's providers to include, but not limited to, medical and behavioral health providers, housing specialists, employment specialist, case managers from other managed care organizations, and agencies. These activities include coordination of services, assisting Members in accessing Community-based resources, and providing Member education. All activities are outcome-based, designed to improve the quality of life and functionality of the individual. By sharing results of assessments and care plans with those on the Members chosen intradisciplinary team (IDT) and consulting with Medical Directors, behavioral health, social workers, pharmacists and other internal/external professionals or resources, this aligns the Member's care team in a holistic approach in achieving the Member's goals and best outcomes.

Discharge Planning

Community Health Choice will promptly assess the needs of a member discharged from a hospital, nursing facility, ICF/IID, inpatient psychiatric facility, or other care or treatment facility. Both physical and behavioral health needs, including substance use disorder treatment, will be assessed. A service coordinator will work with the member's PCP, the attending physician, the hospital, inpatient psychiatric facility, nursing facility or ICF/IID discharge planner, the member, and the member's family to assess and plan for the member's discharge including appropriate service authorizations. Upon receipt of notice of a member's discharge from an inpatient psychiatric facility, a service coordinator will contact the member within one business day. When long-term services and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving appropriate community-based care. The service coordinator will provide information to the member, the member's family, and the member's PCP regarding all service options available to meet the member's needs in the community. For members being discharged from a nursing facility or ICF/IID to the community, we will provide timely access to service coordination and arrange for medically or functionally necessary personal care services (PCS) or nursing services.

Transition Plan

A transition plan is a written plan based on transition needs or issues that should be addressed before the Member is ready to transition to adult care. After transition issues have been identified, action steps are developed with input from the Member and his or her family. The goal of transition planning for Members is to move toward independence.

When a member transfers to Community Health Choice from another MCO, Community Health Choice will receive a transfer packet that includes, at a minimum, the annual reassessment timing, previous assessments, and all active service authorizations. Community Health Choice continues to follow the Member's existing Service Plan and ISP (if applicable) and does not reduce or replace services until the Member has been screened, assessed, and the initial Service Plan and/or ISP is completed by a Community Health Choice Service Coordinator.

Continuity of Care related to Facility Transfer

Residential nursing facility stays are not pre-authorized by Community for STAR+PLUS Nursing Facility Members. Communities network of Nursing Facilities are not required to obtain prior authorization or approval from Community for the transfer of Community's Nursing Facility residents between facilities, regardless of whether the sending or receiving facility is a participating provider in Community's network. Nursing facilities are required to notify Community within one (1) business day of admission, discharge, or transfer of a Community Member within their facilities. Continuity of care, the authorization waiver period and standard prior authorization rules apply to acute, LTSS and add-on services for Members transferring between Nursing Facilities.

Specialist as Primary Care Provider

Members with disabilities, special health care needs, and chronic or complex conditions may make a request to Community Health Choice to use a specialist as the Member's PCP. The specialist must either be: 1) a currently

credentialed and contracted provider in Community Health Choice's network; or 2) be eligible for credentialing according to Community Health Choice's Credentialing Policies and Procedures. The specialist must agree to perform all PCP duties required in the contract including meeting the after hour coverage requirements and other access standards. PCP duties must be within the scope of the specialist's license. The member must have a demonstrated medical need to utilize a specialist as the PCP. Medical need will be determined on a case-by-case basis and will include but not be limited to the following areas:

a. Terminal cancer
b. HIV/AIDS
c. Progressive neurological diseases
d. Members in hospice care

The specialist must be approved by the Medical Director. The specialist must sign a statement stating that he or she is willing to accept responsibility to serve as the Member's PCP and accept Community's reimbursement for non-specialty, PCP-related services.

The Member must sign a statement indicating consent for the specialist to serve as a 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 Member, not later than thirty (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.

Please confirm Member eligibility by calling Community Health Choice Member Services at 713.295. 2300 or 1.888. 435.2850 or access eligibility information on our website at CommunityHealthChoice.org. A copy of the PCP referral should be placed in the Member's medical record.

Please confirm the specialist's network status by calling Community Health Choice Provider Services at 713.295.2300 .

Specialist Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Community Health Choice Members who have been referred by their PCP for specified consultation, diagnosis and/or treatment . The specialist must communicate with the PCP 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 PCP.

The specialist should also respond to requests from Community Health Choice Health Services Department for pertinent clinical information that assists in providing a timely authorization for treatment.

Community Health Choice Members are assured timely access to services and availability of specialty Providers within the established standards. When a Community Health Choice Member receives a specialist referral from his/her PCP, the specialist should review the case with the PCP to determine clearly what services are being requested. Referrals from the PCP must be documented in both the PCP'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. 2300 , fax 713.295.2283 or submit an authorization online at CommunityHealthChoice.org.

Claims submitted for services by specialists for Community Health Choice Members should reference the PCP 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 Health Choice Members have the right to informed choices and to refuse treatment or therapy.

Community Health Choice 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 Health Choice 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 Health Choice 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 Health Choice 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 Health Choice medical director to discuss the course of action. Community Health Choice strongly recommends that Providers encourage Members to complete an advanced directive.

Updates to Contact Information

Please contact Community Health Choice and TMHP 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 privileges
- Telephone number
- Contract status change
- Specialty change
- Group affiliations
- Opening/closure of panel
- Tax ID number
- Patient age limitations
- Medicaid Provider number
- DEA number
- NPI number
- TPI number

- 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 Health Choice and TMHP of any changes to the Provider data listed above. Changes not received in writing are not valid. If Community Health Choice is not informed within the aforementioned time frame, Community Health Choice and its designated claims administrator are not responsible for the potential claims processing and payment errors. Send notification of changes to:

Community Health Choice
Attn: Network Management
4888 Loop Central Dr.
Houston, TX 77081
Fax: 713.295.7058
E-mail: CHC.Contracting@CommunityHealthChoice.org

In addition to updating information with Community Health Choice, Providers must also update their demographic information with Texas Medicaid & Healthcare Partnership (TMHP). To update demographic information in the TMHP Provider Information System (PIMS), please visit the TMHP Medicaid Providers homepage. For more information on using the PIMS, please reference the TMHP PIMS User Guide (pdf)

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

NPI Registry

Providers should review their information on the CMS National Plan and Provider Enumeration System (NPPES) NPI Registry regularly and update their information as needed. Website: **https://nppes.cms.hhs.gov/#/**

Plan Termination

Providers who elect to terminate Community Health Choice participation must, themselves or their respective IPA, provide a 90-day written notice to Community Health Choice by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of your contract with Community Health Choice or your IPA. Community Health Choice 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 Health Choice to efficiently transfer patients to another Provider. Physicians are requested to continue care in progress until all Members can be successfully transferred to new PCPs.

Member Eligibility Verification

Providers must verify Member eligibility via our provider portal or by calling Member Services at 713.295.2300 or 1.888.435-2850 prior to each visit.

Second Opinions

A Member, parent, legally appointed representative (LAR) or the Member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, surgery options or other treatment of a health condition. The second opinion shall be provided at no cost to the Member.

The second opinion must be obtained from a network Provider. If an in-network Provider is not available, Community Health Choice will approve referral to an out-of-network Provider for the second opinion at no cost to the Member. Upon request, Community Health Choice will provide assistance to the Member or requesting PCP/specialist to obtain the second opinion.

Appointment Availability Standards

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

Service	Appointment Availability
Emergent	Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities.
Urgent	Must be provided within 24 hours, including urgent specialty care and behavioral health services
Primary Routine Care	Must be provided within 14 days, including behavioral health
Specialty Routine Care	Must be provided within 21 days
Routine Care Dental	Within eight weeks for dental
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days
Preventive Care Physical/Wellness Exams	Adults (21 years and older): Within 90 days New Members: Within 90 days of enrollment

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 PCP 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

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

Community Health Choice's contracts state that PCPs 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 PCPs must "maintain one of the following to receive calls from Members after normal business hours:"

Acceptable after-hours coverage

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

Unacceptable after-hours coverage

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

Standards for Medical Records

Accessibility and Availability of Medical Records

Community Health Choice 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. All medical records must be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of patient records. Provider must retain medical records for a period of ten years following termination of the Provider's contract with Community Health Choice or longer as mandated by any applicable State or federal law. The Provider must provide Community Health Choice with access to Members' medical records and access to the facility. The Provider must comply with the timelines, definitions, formats, and instructions specified by HHSC and provide requested records within three business days of the request. If at the time of request for access to medical records HHSC or OIG or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide records at the time of request or in less than 24 hours.

Record Keeping

Medical records may be on paper or electronic. Community Health Choice 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 Health Choice sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws. Medical records 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 the contractor and (2) prior admissions, as necessary.
- 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 health care relating to the provision of health care 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:
  - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health Providers when problems are indicated
  - Screening and referral by behavioral health Providers to PCPs when appropriate
  - Receipt of behavioral health referrals from physical medicine Providers and the disposition/outcome of those referrals
  - At least quarterly (or more often if clinically indicated) summary of status/progress from the behavioral health Provider to the PCP
  - 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
  - A written release of information that 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 Health Choice'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

Options for Member Non-Compliance

Contact Provider Services at 713.295. 2300 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 PCP must request (in writing to Community Health Choice) 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.

A PCP must continue to render services 30 days from the date of the letter mailed to the Member and Community Health Choice.

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 PCP cannot transfer a Member to another PCP without the prior written authorization of the Community Health Choice Medical Director. Community Health Choice requests that the physician continue care until Community Health Choice can successfully transfer the Member to a new PCP. PCPs 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 CommunityHealthChoice.org.

Dispute Resolution for Providers

There are certain dispute resolution provisions in the Provider contract. For the purposes of clarity, Community Health Choice 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 Health Choice 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. Additional information is located in the "Complaints and Appeals" section for each program in this manual.

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., vision services) may also have additional specifically related processes.

In compliance with state and federal regulations, URAC standards, and Community Health Choice internal standards, Community Health Choice 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 Health Choice's Provider network. In the event that Community Health Choice takes an action to terminate, suspend or limit a Provider's participation status with Community Health Choice, Community Health Choice will provide a dispute resolution process as delineated:

- **Investigation**

  A routine investigation may be initiated by any Senior Manager of Community Health Choice, 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 Health Choice 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)**

  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 Health Choice, 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.

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 Health Choice, 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:
  - A practitioner's state license or DEA number is revoked, suspended, restricted or placed under probation;
  - A practitioner fails to satisfy an interview requirement;
  - A practitioner fails to maintain malpractice insurance; and
  - 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.

Provider Portal

Community Health Choice'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 CommunityHealthChoice.org > Provider > Register Today. Complete the Secure Access Application and send it to Community Health Choice. We will process your form and provide your login credentials within three business days.

Forms for Providers

Please visit our Provider website at https://provider.communityhealthchoice.org for all Community Health Choice forms. You may download them for your use as needed.

Network Referrals

Network Limitations

Community Health Choice has an open network. Providers are able to refer Members to the Community Health Choice website or the current Community Health Choice Provider Directory. Members may go to any in-network Provider. While we have an open network at this time, we encourage Members to choose a PCP and schedule appointments as needed. If a Provider wants to refer a Member to an out-of-network provider, they must provide justification to Community Health Choice regarding Out-of-Network referrals, including partners not contracted with Community Health Choice.

Referral to Ophthalmologist or Optometrist

Members have the right to select and have access to, without PCP referral, a network ophthalmologist or therapeutic optometrist to provide eye healthcare 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 Navitus.com.

Members with Special Health Care Needs

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

Under certain circumstances, Members may require the regular care of a Specialist. The criteria for a Specialist to serve as a Member's PCP include the Member having a disability, special healthcare needs, or a chronic, life-threatening illness or condition of such complexity indicating:

- The need for multiple hospitalizations is present.
- The majority of care needs to be given by a Specialist.
- Administrative requirements arranging for care exceed the capacity of the non-specialist PCP. This includes Members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology or oncology conditions, etc.

A Member who resides in a Nursing Facility may designate a Specialist as their PCP. Providers who follow NF residents should adhere to the TAC guidelines for required visit frequencies and resident medical record documentation. The Specialist must:

- Agree to be the Member's PCP
- Meet contractual and credentialing requirements for PCP participation
- Provide access to care 24 hours a day, 7 days a week
- Coordinate the Member's healthcare, including preventive care

When such a need is identified, the Member or Specialist must contact Community's Service Coordination department and submit a PCP request form. The Service Coordination department will review the request and submit it to the Medical Director for approval. The Service Coordination team, once approved, coordinates with Community's Member Services team to make the PCP assignment to the Specialist. Community will complete this process, make its determination, and notify the member within 30 days of receiving the request. The designation cannot be retroactive. If the request is approved, Community does not reduce compensation due to the original PCP. If the request is denied, the Member may appeal the decision through Community's Member complaint process. Under that process, Community must respond to a Member's complaint within 30 days. For further information, contact Community's Provider Services at 888-435-2850.

Referral to Specialists and Health-Related Services

PCPs should provide a medical home to Community Health Choice 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 Health Choice 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 Health Choice. A list of these Providers is available online. Authorizations for referrals to in-network specialists are not required. However, the in-network specialist may require a referral from the PCP.

PCPs 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 PCP regarding services rendered, as well as results, reports and recommendations. This is essential to ensure continuity of care for the Member.

The PCP is expected to refer Community Health Choice Members to contracted behavioral health Providers as needed for behavioral health services. If a PCP is unsure whether a patient requires behavioral health services, the PCP is encouraged to refer the patient to a behavioral health specialist to make that assessment. Also, Community Health Choice 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 Health Choice Member to allow the behavioral health Provider and PCP to share this information.

Specialist Scheduling Service

Community Health Choice offers Specialist Scheduling Service to help Community Health Choice Providers locate and make appointments with specialists on behalf of Community Health Choice 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 Website:
https://ProviderPortal.CommunityHealthChoice.org/Providers/Secure/Referrals/Specialist.aspx?product=Medicaid

Phone: 713.295.2450 or 1.888.760.2600

Fax specialist consultant appointment form to 713.295.7050.

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 Health Choice
- The condition is emergent, and the use of a network hospital is not practical for medical reasons

To authorize medical services, please call 713.295.2295, fax 713.295.2284 or submit an authorization online at CommunityHealthChoice.org.

To authorize behavioral health services, please call 713.295.2295 or fax 713.576.0931 (outpatient), 713.576.0932 (inpatient) or submit an authorization online at CommunityHealthChoice.org

Continuity of Care

Pregnant Woman Information

Community Health Choice 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.

Member Moves Out of Service Area

Community Health Choice requests that the Member contact us if they move or change their address or phone number, even if these changes are temporary. If a Member moves out of the service area, they may no longer be eligible.

Members should notify Community Health Choice Member Services at 713.295. 2300 along with 2-1-1 or 1.877.541.7905.

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.

Pre-Existing Conditions

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

New Members

Community Health Choice will ensure newly enrolled members will continue to have access to medically necessary items, services and prescription drugs as well as medical, behavioral health and LTSS providers for the transition period. Members will be allowed to maintain their current providers for 90 days from the date of enrollment. Members will be allowed to keep their current LTSS providers for up to 6 months after initial enrollment or until the Comprehensive Health Risk Assessment has been completed and the Member has signed the Integrated Plan of Care. Members who have a terminal illness at the time of enrollment have up to nine months. New Members will also be allowed to keep their preauthorized services for the duration of the prior authorization or six months from enrollment, whichever is sooner.

Special Access Requirements

Interpreter/Translation Services

Some Community Health Choice Members may need help communicating with their Providers. While we attempt to assign Members to a PCP 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 Health Choice Member who speaks another language, call Member Services at 713.295. 2300 or 1.888.435.2850 to access an interpreter. We usually have Spanish interpreters immediately available. Community Health Choice also has a 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 Health Choice Member Services Department at 713.295. 2300 or 1.888.435.2850 . Once a Community Health Choice 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 that is 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 Health Choice can help Providers communicate with the hearing impaired by telephone with a translation device for the deaf. Call Community Health Choice Member Services TDD/TTY telephone line at 1.800.735.2989 for assistance in any language. Some hearing-impaired Members, especially those who became deaf pre-lingual, may not be able to communicate in writing, but can communicate in sign language. If a Community Health Choice Member needs a face-to- face interpreter in your office, call Community Health Choice Member Services at least three business days in advance of the Member's appointment.

MCO/Provider Coordination

Community Health Choice 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 Health Choice 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 PCP's plan of care
- Provide information to the Member and the Member's family concerning the specialty care recommendations

Please contact Community Health Choice 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 Health Choice 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 Health Choice 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 Health Choice'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 Member Services at 1.877.343.3108 to receive appropriate referrals.

Non-Emergency Medical Transportation (NEMT)

NON-EMERGENCY TRANSPORTATION

The Nursing Facility (NF) is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the NF Unit Rate. Transports of NF Members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians' offices for recertification examinations for NF care are not reimbursable services by Community Health Choice.

Community Health Choice is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

Emergency Services

Emergency Room Services

Emergency room Providers are authorized by Community Health Choice to provide medically necessary and appropriate treatment for any Community Health Choice Member. If a Community Health Choice Member needs to be admitted, the hospital must notify the Community Health Choice Utilization Management Department within 24 hours of the admission or the next business day by either calling 713.295. 2300 or 1.888. 435.2850 , by faxing the encounter record to 713.295.2284 or on our website at CommunityHealthChoice.org. The PCP should also be notified by the hospital about the admission within 24 hours or the next business day. Whenever a Community Health Choice Member presents to an emergency room with a non-emergent condition, the Member must be assessed, and their PCP must be contacted (the name of the PCP is located on the Member ID card) for appropriate treatment or education.

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

- Document attempts to contact the PCP
- Treat the Member

Notify the PCP of services rendered by faxing a copy of the encounter to Community Health Choice at 713.295. 2300 . Community Health Choice will forward a copy to the PCP within 24 hours or the next business day. Follow-up care should be referred to the PCP.

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'
- "Quantity Dispensed" should equal the amount for a three-day supply (Field 442-E7)

Call Navitus Customer Care toll free at 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 in 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. When a Community Health Choice 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 Health Choice 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.

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 Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications 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 that 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 health care
- 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
- Not experimental or investigative.
- Not primarily for the convenience of the Member or Provider.

The mental health priority populations are those individuals served by Texas Mental Health Mental Retardation (TXMHMR). This group is defined as children and adolescents under the age of 18 who exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.

Also included in this group are adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

Behavioral Health Appointment Accessibility Standards

Emergent/Life Threatening	Immediate
Urgent	Within 24 hours
Routine Primary Care	Within 14 days of the request
Initial Outpatient Behavioral Health	Within 14 days
Specialty Routine	Within 21 days
Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission	Within 7 days from the date of discharge

Primary Care Provider Requirements for Behavioral Health

Community Health Choice PCPs must screen, evaluate, refer and/or treat any behavioral health problems and disorders. The PCP 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.

Providers can call Community Health Choice toll free at 1.877.343.3108 to obtain assistance in identifying an appropriate contracted behavioral health Provider for your patient. Members can call the Crisis Line 24 hours a day, seven days a week, toll free at 1.877.343.3108.

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 Health Choice Members may self-refer to any in-network behavioral health Provider.

Community Health Choice Members can also call Community Health Choice at 713.295.2294 regarding how and where to obtain behavioral health services. No prior approval from the PCP is required.

Providers may refer Members suspected of having a developmental delay or a developmental disability, seriously emotionally disturbed (SED), mental illness or chemical dependency by:

- Calling Provider Services at 713.295. 2300 or
- Faxing referral information to our dedicated behavioral health faxes at 713.576.0932 for inpatient or 713.576.0931 for outpatient.

Behavioral Health Services

Community Health Choice's Provider Network makes available behavioral health services to Members for the treatment of mental health as well as drug and alcohol issues by hospitals, chemical dependency treatment facilities licensed by the Department of State Health Services, and practitioners of the healing arts that include:

- Behavioral health assessment and referral services
- Individual, family, and group counseling
- Acute inpatient hospitalization
- Short-term residential
- Partial hospitalization for mental health conditions
- Intensive outpatient programs
- Medication evaluation and monitoring
- Referral for other community services
- Case management

- Attention Deficit Hyperactivity Disorder (ADHD) services
- Targeted Case Management
- Mental Health Rehabilitative Services

Mental Health Rehabilitative Services and Mental Health Targeted Case Management

Mental Health Rehabilitative Services (MHR) and Mental Health Targeted Case Management (MHTCM) must be available to eligible STAR Members who require these services based on the appropriate standardized assessment – either the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS).

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

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

Severe emotional disturbance (SED) means psychiatric disorders in children and adolescents that cause severe disturbances in behavior, thinking, and feeling.

Mental Health Rehabilitative Services (MHR) are those age-appropriate services determined by HHSC and federally approved protocol as medically necessary to reduce a Member's disability resulting from severe mental illness for adults or serious emotional, behavioral or mental disorders for children and to restore the Member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a Member achieve a rehabilitation goal as defined in the Member's rehabilitation plan.

MHR services include training and services that help the Member maintain independence in the home and community such as the following:

- **Medication training and support**: curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- **Psychosocial rehabilitative services**: social, educational, vocational, behavioral or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development
- **Skills training and development**: skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- **Crisis intervention**: intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting
- **Day program for acute needs**: short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Mental Health Targeted Case Management (TCM) means services designed to assist Members with gaining access to needed medical, social, educational, and other services and supports. TCM services include:

- Case management for Members who have SED (children 3-17 years of age), which includes routine and intensive case management services.
- Case management for Members who have SPMI (adults 18 years of age or older).

MHR and TCM services, including any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. Community Health Choice will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but we are not responsible for providing any services listed in the RRUMG that are not covered services. Community Health Choice must accept the level of care

generated by the CANS/ANSA and may not prior authorize MHR /TCM services based on medical necessity. Providers must review a Member's plan of care for MHR services in accordance with the RRUMG to determine whether a change in the Member's condition or needs warrants a reassessment or change in service.

- Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at DSHS.texas.gov/transition/mhsa.aspx.
- Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found at DSHS.texas.gov/transition/mhsa.aspx.

Providers of MHR and TCM services must use, and be trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools to assess a Member's need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Community Health Choice by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. A Provider entity must attest to Community Health Choice that the organization has the ability to provide, either directly or through subcontract, the full array of RRUMG services to Members.

HHSC has established qualifications and supervisory protocols for Providers of MHR and TCM Services. This criterion is located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

Coordination between Behavioral Health and Physical Health Services

PCPs and Behavioral Health Providers must work with Community Health Choice to be in compliance with parity and comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations.

Behavioral Health Providers should send initial and quarterly, or more frequently if clinically indicated, summary reports of a Member's behavioral health status to the PCP. Member or the Member's Legally Authorized Representative (LAR) must provide consent for the release of such information to the PCP.

Behavioral Health Providers may only provide physical healthcare services if they are licensed to do so. Behavioral Health Providers must refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's LAR's consent.

Behavioral Health Providers Medical Records Documentation

Community Health Choice contracted behavioral health 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 Health Choice 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 that 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

Community Health Choice provides benefits for Medicaid- -covered inpatient and outpatient psychiatric services to Members birth through age 20 and ages 65 and older who have been ordered to receive the services by a court of competent jurisdiction, including services ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.
Community Health Choice:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric services for Members age 20 and younger or ages 65 and older; any modification or termination of services will

be presented to the court with jurisdiction over the matter for determination.
- Will comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.
- Will not allow Members ordered to receive treatment under a court-ordered commitment to appeal the commitment through our complaint or appeals processes.
-

Coordination with Local Mental Health Authority (LMHA)

LMHAs and other approved Providers contracted with Community Health Choice can also perform assessments to determine eligibility for rehabilitative and targeted MHMR case management services. Providers of outpatient behavioral health services who believe their Community Health Choice 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 DSHS.state.tx.us/mhservices/.

Community Health Choice actively coordinates behavioral health care with the local LMHA's within the specific services areas, including The Harris Center, Tri-County Services MHMR, Spindletop MHMR, Texana Center, and Burke Center MHMR.

Assessment Instruments for Behavioral Health: PCP Toolkit

Community 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 PCPs are the center of care for many patients who have both physical and behavioral health disorders. To support PCPs, 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 PCPs can help their patients understand their diagnoses and take the right steps to become and stay healthy.

Conditions included in the toolkit:

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

Providers may access the PCP Toolkit online at www.CommunityHealthChoice.org.

Inpatient Discharge Follow-Up and Missed Appointment Procedures

Community Health Choice Members receiving inpatient psychiatric services must be scheduled for outpatient treatment prior to discharge. They must receive outpatient treatment within seven days from the date of discharge and a follow up appointment within 30 days after hospitalization for mental illness. 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.
Members with behavioral health diagnosis are also monitored for readmission to an inpatient facility. Results of these reports and focused studies are available to Providers upon request.

Physical Health Lab/Ancillary Tests

Behavioral health Providers are required to refer Members with physical health problems to their PCP for treatment.

Providers should utilize participating laboratory vendors to provide analysis of labs related to outpatient psychiatric medication management.

Behavioral Health Focus Studies and Utilization Management Reporting Requirements

Community Health Choice is 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 Health Choice will complete and make available to the Provider.

Dental Services

Role of Main Dental Home

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.

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

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 from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at 1.800.964.2777.

Emergency Dental Services

Medicaid Emergency Dental Services:

Community Health Choice 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 covered emergency dental procedures.

- Covered emergency dental procedures include, but are not limited to:
- alleviation of extreme pain in oral cavity associated with serious infection or swelling;

- repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- open or closed reduction of fracture of the maxilla or mandible;
- repair of laceration in or around oral cavity;
- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- incision and drainage of cellulitis;
- root canal therapy. Payment is subject to dental necessity review and pre- and post- operative x-rays are required; and
- extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.C

Non-Emergency Dental Services

Medicaid Non-Emergency Dental Services:

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

Community Health Choice 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 ages 6 through 35 months.

Medical Providers for Texas Health Steps must complete training and become certified to provide the intermediate oral evaluation and fluoride varnish application before providing these services. Federally qualified health center (FQHC) Providers will be certified at the facility level. Training for certification is available as a free continuing education course on the Texas Health Steps website at www.TXHealthSteps.com/.

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 (99381, 99382, 99381, or 99392 medical checkup procedure code).
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier and diagnosis codes Z00.121 or Z00.129.
- Documentation must include all components of the OEFV.
- Texas Health Steps Providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Members' file.

Pharmacy

Pharmacy benefits for Community Health Choice 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 Navitus.com. The Navitus formulary adheres to the VDP formulary and preferred drug list and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called HHSC's DUR Board and VDP.

Role of Pharmacy

Community Health Choice 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 contracts with most pharmacies.

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

Pharmacy Provider Responsibilities

Pharmacy Providers participating in the Texas Medicaid Program or CHIP Programs must:

- Adhere to the formulary
- Adhere to the preferred drug list (PDL)
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible
- Coordinate benefits when a Member also receives Medicare Part D services or other insurance services.

How to Find a List of Covered Drugs

Drugs eligible for reimbursement are listed in the current Texas Medicaid formulary. The formulary is available at 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.txvendordrug.com/formulary/prior-authorization/preferred-drugs.

How to Find a List of PA Required Services and Codes

A list of covered drugs is available via the provider portal or at https://txstarchip.navitus.com/pages/formulary.aspx. 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. “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 website.

Navitus processes Texas Medicaid pharmacy PAs for Community Health Choice. 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 Program website, ePocrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms at Navitus.com under the “Prescribers” section or have them faxed by Customer Care to the prescriber’s office. Prescribers will need their NPI number and State to access the portal. Completed forms can be faxed 24 hours a day, seven days a week to Navitus at 1.855.668.8553.

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. and 5:00 p.m., Mon. – Fri. (CST). After hours, Providers may leave a voicemail. Decisions regarding PA will be made within 24 hours for STAR and three business days for CHIP 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 may 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 not all criteria are 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 submit prior authorization request to Navitus. Additional details including pharmacy billing instructions are located in the Navitus Pharmacy Provider Manual on the Navitus website at https://txstarchip.navitus.com/pages/formulary.aspx. For questions regarding Navitus, call 1.877.908.6023 or visit the Navitus website at Navitus.com.

If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. The 72-hour emergency fill is for any Medicaid recipient. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy may fill 72-hour emergency supply of the drug.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Community Health Choice reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the NF unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

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 Health Choice 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).

Authorizations for Health Services

Prior Authorization

Prior authorization (sometimes referred to as pre-certification or pre-notification) determines whether non-emergent medical treatment is medically necessary, is compatible with the diagnosis, if the Member has benefits, and if the requested services are to be provided in the appropriate setting.

Prior authorization is not a guarantee of payment. Regardless of whether a Provider obtained the required prior authorization, Community Health Choice must process a Provider's claim according to eligibility, contract limitations, and benefit coverage guidelines. Community Health Choice will adjudicate and process claims according to the terms and conditions of the Provider's contract with Community Health Choice.

Services Requiring Authorization

The list of services and Nursing Facility Add-On services requiring prior authorization is on the Prior Authorization Guide located on the Provider Portal, at CommunityHealthChoice.org > For Providers > Provider Tools > Authorization/Notifications. The guide may not include all services that require or do not require prior authorization. Please call 713.295. 2300 for further information if you are unsure of prior authorization requirements. The list of services is subject to change and will be updated as required.

Clinical Practice Guidelines

Clinical Practice Guidelines are reviewed by the chief medical officer and/or the medical director(s) and Medical Care Management Committee at minimum annually and updated at least every two years. Clinical Practice Guidelines address the following domains:

- Disease Management
- Complex Case Management
- Two behavioral health conditions, one of which addresses children and adolescents
- Preventive Health Guidelines for the following:
    - Perinatal care
    - Care for children up to 24 months old

- Care for children 2 – 19 years old
- Care for adults 20 – 64 years old
- Care for adults 65 years and older

Providers are informed about availability of the guidelines through various methods including Provider newsletters, Community Health Choice's website, Provider manual, Provider services staff, and as needed through faxes.

InterQual

Community Health Choice utilizes InterQual Criteria for evidence-based clinical guidelines for medical and behavioral health services.

InterQual is a nationally recognized utilization management (UM) tool that will provide us with reliable, evidence-based clinical decision support. InterQual is trusted by more than 4,600 hospitals and facilities and more than 280 managed-care organizations. InterQual criteria is also continuously updated with the most recent evidence and clinical standards, using a wide variety of medical specialists to manage and validate their medical criteria sets.

InterQual is known for its clinical integrity, innovative technology and service excellence. We are confident it will help us continue to meet the following objectives:

- Assure optimal and consistent utilization management decision-making
- Support the appropriateness of care
- Manage medical costs
- Foster appropriate utilization of resources

Prior Authorization Requests

Community Health Choice accepts Community Health Choice's Preferred Prior Authorization Form as well as the Texas Standard Prior Authorization Form. 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 for authorization of services.

Community Health Choice strives to provide excellent service to our entire network and will continue to work toward improving your experience with us. Providers will soon receive additional information about a solution in our Provider Portal with benefits including:

- Easy submission of prior authorization requests via the Provider Portal,
- Access to an online catalogue of procedures that require Prior Authorization, and
- Visibility of authorization status.

Essential Information

Providers must submit the Prior Authorization Request Form. The form must include the following information to initiate the prior authorization review process:

- Member name
- Member date of birth
- Member number or Medicaid number
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Rendering provider's name
- Rendering provider's National Provider Identifier (NPI)
- Service requested:
  - Current Procedural Terminology (CPT),
  - Healthcare Common Procedure Coding System (HCPCS), or

    - Current Dental Terminology (CDT)
- Service requested start and end date(s)
- Quantity of service units requested based on the CPT, HCPCS, or CDT requested

Please note any prior authorization requests missing essential information will not be processed and a new request will need to be submitted.

Supporting Clinical Documentation

Providers will find a list or description of any supporting documentation or other documentation necessary to obtain prior authorization for a specified service at provider.communityhealthchoice.org/resources/prior-authorization-information/.

Lack of Information

When Community receives a request for prior authorization and the request does not contain complete clinical documentation and/or information:

- Community will notify the Member by letter that an authorization request was received, but cannot be acted upon until Community receives the missing documentation/information from the requesting Provider. The letter will include the following information:
    - A statement that Community has reviewed the PA request and is unable to make a decision about the requested services without the submission of additional information.
    - A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
    - An applicable timeline for the provider to submit the missing information.
    - Information on the manner through which a provider may contact Community.
- Community will contact Provider via fax or phone and request documentation for completion of the medical necessity review within three business days of Community's receipt of request.
- If Community does not receive the documentation/information by the end of the third business day of Community's request to the requesting Provider, the request will be submitted to the Medical Director no later than the seventh business day after receipt of request.
- Community will make a decision no later than the tenth business day after the request received date.

Start of Care (SOC) exceptions will be approved when a Provider is able to submit additional information sufficient to classify a request as complete and the MCO has determined that requested services meet medical necessity from the SOC date.

Service	Initial Authorization	Re-certification of Authorization
Therapy (PT/OT/ST)	Initial prior authorization (PA) requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request was received.	Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the request is received. Should not be received >30 days before expiration of previous authorization.
Private Duty Nursing	Initial requests must be submitted within three business days of the SOC date.	A recertification request must be submitted at least 7 calendar days before, but no more than 30 days before, a current authorization period will expire.
DME	Prior authorization must be obtained for some supplies and most DME within three business days of the DOS.	Prior authorization must be obtained for some supplies and most DME within three business days of the DOS.

Failure to Obtain Prior Authorization or Referral

For any covered service rendered to, prescribed or authorized for Members by Provider in a non-emergent situation for which Community Health Choice or payor requires Prior Authorization in advance of the delivery of service, which Prior Authorization was not obtained by Provider in advance, Provider understands that Community Health Choice or Payor will deny Provider's claim for said covered services. In no event will Member be financially responsible for payments arising for such services, except for applicable Member expenses as may be required under a benefit plan/program.

Prior Authorization Determination Timeframes

Community issues a determination within the following timeframes according to state regulatory requirements.

Prospective Review

- Emergency Medical or Emergency Behavioral Conditions do not require prior authorization
- Urgent - As soon as possible based on the clinical situation, but no later than one business day from receipt of a request for a Utilization Management (UM) determination
- Routine - Within three business days from the receipt of a request for a UM determination
- Inpatient - Within one business day from the receipt of a request for a UM determination
- Post-hospitalization or life-threatening conditions - within one hour from the receipt of a request.

Concurrent Review

Community issues the determination for reduction or termination of a previously approved course of treatment early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs, but no longer than two business days.

Retrospective Review

Based on the Retrospective Review Policy for authorizations, if certain conditions are met Community will issue a determination, Community will issue a determination within 30 calendar days from the receipt of request for a

retrospective UM determination for a service that Provider has already rendered and for which Provider has not submitted a claim. Fax requests for Retrospective Review with supporting documentation to 713.576.0937.

Peer-to-Peer

If an authorization request does not meet medical necessity, a Medical Director will review the request. Community will send a fax notification to the requesting Provider with the offer of a Peer-to-Peer. To request a Peer-to-Peer discussion, please call 713.295.2319.

Authorization for Out-of-Network Services

A Provider may request authorization for out-of-network services which cannot be provided within the Community Health Choice network. To request an out-of-network authorization, submit an Authorization Form on Community Health Choice's website CommunityHealthChoice.org or by fax to 713.295.2283. Community Health Choice'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 Health Choice network, presenting pertinent clinical information and medical necessity. All denials are the responsibility of the medical director.

Utilization Management Reporting Requirements

Community Health Choice 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 Health Choice will complete and make available to the Provider

Utilization Management Reporting Requirements

Community Health Choice's Quality Management is involved in conducting clinical and service utilization studies that may or may not require chart reviews. **Community Health Choice conducts gap analysis of the acute care and nursing facility add- on services is conducted to trend and identify opportunities for improvement with our Nursing Facility providers**.

Quality Management

Quality Improvement Program

The Quality Program's overall objectives are to maintain a quality improvement program that promotes objective and systematic measurement, monitors and evaluates services and work processes, and then implements quality improvement activities based on the outcomes. This includes but is not limited to the following areas:

- Healthcare access
- Healthcare delivery
- Contracting and contract administration
- Provider credentialing

- Peer review
- Customer service and satisfaction
- Provider service and satisfaction
- Risk minimization
- Utilization management and appeals
- Care (disease) management and complex case management
- Preventive and interventional healthcare services
- Delegation oversight and compliance

Community Health Choice performs ongoing monitoring of clinical/administrative activities to assure high quality service delivery. This is reflected in the Operations Report, which is reported at the Community Health Choice Boards of Directors meetings. The Quality Optimization Committee also tracks and trends quality metrics throughout the year and reports trends and action plans.

Quality Improvement Health Services Contracting

Community Health Choice contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI program.

Community's contracts specify that practitioners and providers cooperate with Quality Improvement (QI) activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs.

Community Health Choice has the right to use performance data based upon the below citation in the contract:

Facility (P 1.28) and Provider & Ancillary (P 1.30)

> "Provider Manual. The Community document, incorporated in its entirety by reference here, containing administrative policies and procedures relating to issues such as credentialing, utilization management, claims payment, provider complaints or appeals and quality improvement."

- Community Health Choice in its sole discretion, including but not limited to quality improvement activities; such as HEDIS reporting, Provider Incentive Programs, public reporting to consumers, and potential preferred status designation.

Quality Improvement Studies

The purpose of healthcare quality improvement projects 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 Health Choice, Providers, and Members to have confidence in the reported improvements, projects 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 the project purpose, design, and methodology. Findings and recommendations from the project are to be communicated to the Provider network as warranted through faxes, newsletters, and the website. Data and information specific to the project findings may also be communicated through the medical director or nurse reviewer during scheduled office visits.

Quality Management for STAR+PLUS

As part of our quality management program, we submit quarterly reporting to the Texas Health and Human Services Commission. We share the number of:

- Critical incident and abuse reports for members we have received from care providers.
- Our service coordinators who have received consumer-driven services (CDS) training.

Performance Improvement Projects

Each year, the Texas Health and Human Services provide Community Health Choice with two Performance Improvement Projects (PIP) topics for Medicaid and CHIP programs. At any given time, Community Health Choice maintains two ongoing PIPs for STAR, CHIP, and STAR+PLUS with one PIP being conducted in collaboration with other MCOs, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or community organizations. The purpose of the healthcare quality PIPs is to assess and improve processes, and thereby outcomes, of care.

Quality Improvement Projects

To support URAC accreditation, Community Health Choice identifies Quality Improvement Projects through the recommendation of the Executive Quality and Compliance Committee after reviewing clinical studies and outcomes for the previous year. These projects are prioritized resulting in activities designed to:

- Support the overall quality management strategy approved by clinical leadership
- Result in a positive measurable impact
- Provide improvement on consumer health outcomes or internal work processes
- The three Quality Improvement Projects are as follows:
    - Improving 7 and 30-day follow-up appointments after hospitalization for mental illness
    - Improve health outcomes for STAR/CHIP Members through Community Health Choice's Asthma Care Management Program
    - Improve well-child appointment rates for Community Health Choice (e.g., HEDIS W30, CIS, IMA, and WCC)

Pay for Quality (P4Q) Program

The quality focus areas for Texas Health and Human Services include prevention, chronic disease management, and maternal and infant health. To this end, Texas Health and Human Services created the Pay for Quality (P4Q) program, which includes both HEDIS and non-HEDIS measures. Program measures are updated annually. Community Health Choice collaborates with both Texas Health and Human Services and our Providers to improve performance in the identified measures.

Billing and Claims

Nursing Facility Claims Filing

All Nursing Facility providers must follow and meet HHS' criteria for clean claims submissions as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual" and as noted below.

HHS Clean Claim Criteria:

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed.
- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed.
- The Nursing Facility resident must have a current Medicaid necessity determination for the dates of service billed.
- The Nursing Facility provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

Note: Any claim that does not meet the definition of a clean claim is considered a "non-clean claim." Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Nursing facilities (NFs) may bill Community Health Choice at any frequency they wish. We provide several electronic vehicles to facilitate your submissions. Please note the important information below:

- Clean claims for NF unit rate and NF Medicare Coinsurance submitted for Medicaid members are adjudicated within 10 days from the date the provider submits a clean claim. Clean claims not adjudicated within 10 days of submission by us are subject to interest payments. Claims must be filed within 365 days of the date of service.
- Clean claims for NF add-on services or other services negotiated into the provider's contract and submitted for Medicaid members are adjudicated within 30 days from the date we receive a clean claim. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Claims must be filed within 95 days of the date of service.
- Adjudication edits are based on the member's eligibility, benefit plan, authorization status, HIPAA coding compliance and our claim processing guidelines. Claim coding is subject to review using code-editing software.
- Claim reimbursement is based on the provider's contract. We are responsible for paying qualified providers their liability insurance and an enhanced fee to NF providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment program. The fees are built into the provider's unit rate payment fee schedule.
- Claims submitted by an NF must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual

Nursing Facility - Time Limit for Submission of Claims/Claims Reconsideration

Nursing Facilities must file daily unit rate first time claims within 365 Days from the date of service. If a claim is

not received by Community Health Choice within the 365 Days, Community Health Choice will deny the claim unless there is an exception from the filing deadline.

If the Nursing Facility files with the wrong health plan or the wrong HHS portal within the required 365 Days and produces documentation demonstrating timely filing, Community Health Choice will honor the initial filing date and process the claim without denying for the sole reason of passed timely filing. The Nursing Facility must file the claim with Community Health Choice within: (1.) 365 Days after the date of service, or (2.) 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor.

When a service is billed to a third-party insurance resource other than to Community Health Choice, the claim must be refiled and received by Community Health Choice within: (1.) 365 Days from the date of service, or (2.) 95 Days after the room and board first time claim date on the R&S Report or explanation of payment from the other carrier or contractor. Community Health Choice will require that the Nursing Facility file their claim with a copy of the third-party payor's R&S Report or explanation of payment.

A claim should not be filed with different RUG or split authorized service levels. Each claim must only bill for one RUG or service authorized date span which may result in a separate claim. No later than 10 Days after the Submission Received Date of a Clean First Time Claim, Community Health Choice must: (1.) pay the total amount due of the claim or part of the claim or (2.) deny the entire claim, or part of the claim and notify the provider defining the reasons why the claim will not be paid. Payment is considered paid on the date of: (1.) the date of issue of a check for payment and its corresponding Explanation of Payment or (2.) electronic transmission, if payment is made electronically.

MMP Nursing Facility Outpatient Clean Claim Adjudication

Community Health Choice will Adjudicate SNF Daily Rate clean claims no later than 30 days after the submission to the Community Health Choice portal or HHSC's designated portal, whichever occurs first.

Appeal of MMP Nursing Facility Outpatient Claim

Nursing Facility is allowed 120 days from the date of the initial denial notification to submit an appeal. See Complaints and Appeals chapter for more details.

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 Health Choice is in compliance with HIPAA EDI requirements for all electronic transactions. Providers should submit electronic claims in accordance with ASCX12 Version 5010 format.

Electronic Claims

Professional or Institutional claims can be submitted through Community's clearinghouse in single claim or batch claim submission files.

Community Health Choice receives electronic transactions through the following clearinghouses:

Clearinghouse	Phone Number	Payer ID
Change Health Care Solutions, Inc. (formerly Emdeon; formerly Relay Health)	1.877.469.3263	48145
AVAILITY	1.800.282.4548	48145

Contact your clearinghouse for questions regarding electronic claims submission.

Submitting Claims in the Community Health Choice Provider Portal

The Provider must be logged in to the Community Health Choice website in order to submit a claim. Only professional claims are
accepted. Claims entry is based on CMS 1500 form.

After logging in, select "Submit Claim (Medicaid/CHIP)" on the Secured Pages option to access the claim submission page. If you do not have permission to access the page, please contact your administrator to request permission.

Submitting Claims by Mail for Nursing Facility Add-On Claims

Nursing Facility unit daily rate and coinsurance claims must be submitted electronically and paper claims will not be accepted.

Nursing Facility Add-On claims may be submitted by mail to the following address:

Community Health Choice (Effective February 15, 2023) Attn:
Claims
P.O. Box 981840
El Paso, TX 79998-1840

Or by certified mail to the following address:

Community Health Choice
Attn: CLAIMS
4888 Loop Central Dr.
Houston, TX 77081

Refund Lockbox Address:

Community Health Choice Refund
P.O. Box 4818
Houston, TX 77210-4818

Clean Claims Payment

A clean claim is defined as a claim submitted by a physician or Provider for healthcare 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 10 days of submission. A Provider will be notified in writing, if additional information is needed to process claim. If a “clean” claim is not adjudicated within 10 days of submission, claim continues to go unadjudicated.

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.

Required Information for CMS 1500 and UB-04 Claims

Forms must include the following information (HIPAA-compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider’s tax ID number
- Total charge
- Provider’s name according to the contract
- NPI of billing Provider
- Billing Provider’s taxonomy codes
- NPI of rendering Provider
- Rendering Provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of ordering/referring/supervising Provider when applicable
- Any other state-required data
- NDC codes

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

- 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 Health Choice website at CommunityHealthChoice.org.
- Corrected claims must be sent within 120 days of initial claim disposition. Failure to mark the claim as "Corrected" could result in a duplicate claim and be denied for exceeding the 95 days timely filing deadline.
- Community Health Choice follows TMHP billing standards for STAR+PLUS. Community Health Choice follows TDI Clean Claims guidelines for CHIP. If any special billing requirements are necessary (e.g. newborns, value-added services, SSI, compounded medications, NEMT Services, etc.), Community Health Choice will inform the Provider.

Ordering, Referring, and Prescribing Providers

All Providers who order, refer and prescribe for Medicaid, CHIP, and CHIP-P Members must be enrolled in the Texas Medicaid Program. Claims for the payment of items or services ordered, referred, and prescribed that do not include the NPI of the physician or other professional who ordered, referred or prescribed the items or services will be denied. The ordering, referring, and prescribing Providers Frequently Asked Questions (FAQ) is also available on the TMHP website, http://www.tmhp.com/TMHP_File_Library/FAQ/ORP_Providers_FAQs.pdf.

Rendering Provider Requirement

Community Health Choice requires all professional and institutional claims for STAR, STAR+PLUS, CHIP, and CHIP-P to include the Rendering Provider NPI for all claims submitted. Community Health Choice will deny claims if the Rendering Provider NPI is not present on the claim.

Reimbursement Methodology

Nursing Facility Unit Rate

Nursing Facility Unit Rates will continue to be authorized by HHS. Community Health Choice will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Nursing Facilities must submit an electronic version of the Medicare Remittances and Advice Form.

The Nursing Facility Unit Rates are the types of services included in the HHS daily rate for Nursing Facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs. This also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility add-on services.

It is important to note that HHS will continue to authorize the daily rate as well as make the medical necessity determinations. Nursing Facilities are required to submit the Minimum Data Set (MDS) form to Centers for Medicare and Medicaid Services (CMS) and Long-Term Care Medicaid Information (LTCMI) form to the LTC Online Portal. For additional information on Texas Minimum Data Set (MDS) visit https://hhs.texas.gov/doing-business-hhs/providerportals/long-term-care-providers/nursing-facilities-nf/texas-minimum-data-set-mds.

Providers should contact Community Health Choice Provider Services for questions related to claims procedures. Please submit a Medicaid Eligibility Service Authorization Verification (MESAV) for any discrepancies identified.

Please note that SAS information is obtained by Community Health Choice after it is posted to the TMHP website. Delays can be

expected between data appearing on the TMHP website and Community Health Choice Secure Provider Portal. The uniform

billing requirements can be found in the HHS Uniform Managed Care Manual (UMCM), Chapters 2 Texas Claims Procedures: https://hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texasmedicaid-chip-uniform-managed-care-manual

Adjusted Claims-Daily Unit Rate

There may be occasions in which a claim, which is in a paid status, may require a payment adjustment. Community Health Choice will monitor and re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are identified by Community Health Choice, and facility providers are not required to take any action. Some of the reasons a claim may require an adjustment are due to changes in:

- Nursing Facility daily rates
- Provider contracts
- Service authorizations
- Applied income
- Level of service/Resource Utilization Group (RUG)
- Non-compliance with spending and staffing requirements as dictated by HHS's Direct Care Rate Enhancement Program.

Community Health Choice will re-adjudicate claims affected by the change. Payment on adjusted claims will be made within 30 Days from receipt of the adjustment reason. When a subsequent claim submission is necessary as result of a SAS related claim denial, please submit as a corrected claim within 120 Days of the applied SAS denial.

Applied Income – Nursing Facility Unit

Within three Business Days after the effective date of the Nursing Facility member, Community Health Choice will provide the name and contact information of a Service Coordinator or designated representative who will assist with the collection of applied income from the Nursing Facility member. Community Health Choice will notify the provider within

10 Days of any change to the assigned Service Coordinator or designated representative. The provider must make reasonable efforts to collect applied income, document those efforts. The provider should notify Community Health Choice Service Coordinator or designated representative when they have made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the provider's existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40 TAC § 19.2316.

Claims Filing Guidelines for Add-On Services

A clean claim must include Community Health Choice published requirements for adjudication such as the appropriate Medicaid number, TIN number, NPI and taxonomy or medical records. For additional information on billing guidelines including taxonomy placement, please reference Claims and Encounters Administration Chapter NF Provider Manual.

Please use the ANSI ASC X12 837P 5010 format for PT, OT, ST, Customized Power Wheelchairs (CPWC) and Augmentative Communication Devices (ACD) and ANSI ASC X12 8371 5010 format for Ventilator and Tracheostomy Care add-on services. Claims filed for add-on services must conform to national billing standards.

Claims for add-on services must be filed with Community Health Choice within: (1.) 95 Days after the date of service, or (2.) 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor. However, if a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next Business Day following the weekend or holiday.

Monthly Capitation Services

Providers contracted under capitated reimbursement methodologies receive payment on a per-Member-per-month (PMPM) basis. Providers receiving capitation are required to submit encounter data to Community Health Choice for services covered under capitation. Refer to your Provider contract or call Community Health Choice Provider Services at 713.295. 2300 for more information.

Adjudication of Claims

Community Health Choice utilizes CMS, state Medicaid, and/or other nationally recognized claims and payment processing policies, procedures, and guidelines to process claims efficiently and provide accurate reimbursement.

Community Health Choice shall adjudicate (finalize as paid or denied adjudicated) Clean Claims for:

(a) Nursing facility services (excluding add-on services) within 10 days of submission;

(b) pharmacy services no later than 18 days of receipt if submitted electronically or 21 days of receipt if submitted non-electronically; and

(c) Community Health Choice will pay Providers interest at a rate of 18% per annum on all clean claims that are not adjudicated within 10 days of submission.

Community Health Choice must withhold all or part of payment for any claim submitted by a Provider for any of the following reasons:

a) excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Abuse or Waste;

b) on payment hold under the authority of HHSC or its authorized agent(s);

c) with debts, settlements or pending payments due to HHSC or the state or federal government;

d) for neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHSC;

e) for maternal services provided on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHSC.

In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified in items (d) and (e) above do not apply to emergency services that must be provided or reimbursed under state or federal law.

Resolving a Level of Care Determination

Medical necessity determinations for the daily unit rate are the responsibility of the HHS' administrative services contractor, Accenture. Accenture will review the information received on the MDS form and use the information to assign a Resource Utilization Groups (RUG) level. The MDS form will provide a comprehensive summary of the member's mental and physical issues which should be completed by the fifth Day after admission to a Nursing Facility.

The determination of the RUG level is based on facility considerations, including facility needs, nursing care and the amount of therapy provided per week. The RUG level determines the amount of money per Day that Medicare will pay for a member's stay at the Nursing Facility. If a member is informed that medical necessity is denied by an Accenture physician, the member has the right to appeal that decision. The member or the member's licensed authorized representative (LAR) or physician may file an appeal directly to Accenture:

Texas Health and Human Services
HHS Administrator Contract Management
PO Box 204077, Mail Code 91-X

Reminder about NCCI Guidelines and Currently Published Procedure Code Limitations

The Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Bulletin are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index web page for correct coding guidelines and specific applicable code combinations. In instances when Texas Medicaid medical policy is more restrictive than NCCI medically unlikely edits (MUE) guidance, Texas Medicaid medical policy prevails.

Claims Audits

With the following exceptions, Community Health Choice must complete all audits of a Provider claim no later than two years after receipt of a clean claim, regardless of whether or not the Provider participates in Community Health Choice's network:

a) in cases of Provider Fraud, Waste, or Abuse that Community Health Choice did not discover within the two-year period following receipt of a claim;

b) when regulatory officials or entities conclude an examination, audit or inspection of a Provider more than two years after
Community Health Choice received the claim;

c) when HHSC has recovered a capitation from Community Health Choice based on a Member's ineligibility.

If an exception to the two-year limitation applies, Community Health Choice may recoup related payments from Providers.

If an additional payment is due to Provider as a result of an audit, Community Health Choice must make the payment no later than 30 days after it completes the audit. If the audit indicates that Community Health Choice is due a refund from Provider, except for retroactive changes to a Member's Medicaid eligibility, Community Health Choice must send Provider written notice of the basis and specific reasons for the recovery no later than 30 days after it completes the audit. If the Provider disagrees with Community Health Choice's request, Community Health Choice must give Provider an opportunity to appeal and may not attempt to recover the payment until the Provider has exhausted all appeal rights.

Overpayments

An overpayment can be identified by the Provider or Community Health Choice. If Provider identifies the overpayment, please submit a completed Overpayment Refund Notification Form with all refund checks and supporting documentation. **Provider can also call a Provider Relations Specialist at 713.295.2295 and approve a recoupment from any future payments to Provider**.

Provider Relations Specialist means a designated MCO representative who is proficient in Nursing Facility billing matters and able to resolve billing and payment inquiries.

If Community Health Choice identifies the overpayment, a recovery letter will be sent to Provider, and Provider has 45 days to submit a refund check or appeal the refund request. If Provider does not respond within 45 days from the date of the recovery letter, Community Health Choice will begin the recoupment on any future payments.

Please mail all refund checks with a copy of the Overpayment Refund Notification Form to the following address:

Community Health Choice Attn:
Medicaid/CHIP Claims
P.O. Box 4818
Houston, TX 77210-4818

Once Community Health Choice has reviewed the overpayment, Provider will receive a letter explaining the details of the reconciliation.

In the event Members retroactively disenroll from Community Health Choice as a result of changes in their eligibility, Community Health Choice reserves the right to automatically recover payments made to Provider for services rendered to those Members.

Provider Preventable Conditions

Community Health Choice is required to use the present on admission (POA) indicator information submitted on inpatient hospital claims and encounters to reduce or deny payment for Provider preventable conditions. This includes any hospital-acquired conditions or healthcare acquired conditions identified in the Texas Medicaid Provider Procedures Manual (TMPPM). Reductions are required regardless of payment methodology and apply to all hospitals, including

behavioral health hospitals.

Potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than the natural progression of the underlying medical conditions. Potentially preventable re-admissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

HHSC sends reports of PPR and PPC performance to Community Health Choice, including hospital lists, effective dates, and reduction data. We apply those reductions for each hospital on the report, including behavioral health hospitals. Community Health Choice notifies each hospital on the list in writing of the applicable reduction amounts. As a payer of last resort, overpayments are subject to recovery and/or recoupment.

Pass Through Billing

Community Health Choice does not allow pass-through billing, and these charges should not be passed on to our Members. For laboratory services, Community Health Choice will only reimburse you if you are certified to perform these services, and Community Health Choice has a record of your CLIA certification on file.

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 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. Neither Community Health Choice nor a Provider may hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the 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.

Out-of-Network Provider Payments

Community Health Choice 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 Health Choice pays network Providers, an amount negotiated between Provider and Community Health Choice, or the standard non-participating rate of 95% of Texas Medicaid.

Community Health Choice 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 Health Choice for that Member's care. Community Health Choice expects Providers billing for out-of-network emergency care to submit claims within 95 days from the date of service. Community Health Choice will adjudicate "clean" claims submitted for out-of-network emergency care within 30 days from Community Health Choice's receipt of the claim.

Community Health Choice Claims Payment

Community Health Choice offers payment solutions that provide innovative options for Providers to receive payments. Community Health Choice partnered with Change Healthcare and ECHO Health, Inc. to provide these new electronic payment methods. Below we have outlined the payment options and any action items needed by your office:

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

2. **EFT/ACH** – Setting up electronic fund transfer (EFT) is a fast and reliable method to receive payment. In addition to your banking account information, you will need to provide a Change Healthcare payment draft number and payment amount as part of the enrollment authentication. After enrolling, funds will be deposited directly into your bank account. If you are interested in receiving EFT, you can enroll by providing your banking information along with an ECHO payment draft number and payment amount to authenticate your enrollment. If you would like to sign up for EFT, you have two options:

    - To sign up to receive EFT through Settlement Advocate for Community Health Choice only, visit https://view.ECHOHealthInc.com/EFTERADirect/CommunityHealthChoice/index.html.
    - To sign-up to receive EFT from all payers processing payments on the Settlement Advocated platform, visit https://view.ECHOHealthInc.com/EFTERA/efterainvitation.aspx. A fee for this service may apply.

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

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

If you have additional questions regarding your payment options, please contact ECHO Health toll free at 833.629.9725.

Coordination of Benefits

Community Health Choice administers benefits according to the Texas Insurance Code § 843.349 (e) and (f), and for Medicaid MCOs, chapter 42, section 433.139 of the Code of Federal Regulations (CFR). Community Health Choice is the payer of last resort when other insurance is in effect. When other primary insurance information is not identified, Community Health Choice will pay all covered medical services. Upon notification that other primary insurance exists, Community Health Choice shall employ all reasonable actions to pursue recovery of benefits paid as primary.

Providers must submit claims to other health insurers for consideration prior to billing Community Health Choice. A copy of the other health insurer's EOB/EOP or rejection letter should be submitted with the claim to Community Health Choice. If we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the Provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue post-payment recovery.

Provider Payment Reconsideration

Claims Questions/Status

Providers can check claims status, Member eligibility, and a variety of other services online via our Provider Portal. You must sign up for this service. To learn more, visit CommunityHealthChoice.org.

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

Contact Provider Services during regular business hours:

Local: 713.295. 2300 or Toll Free: 1.888. 435.2850

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

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

Provider Payment Reconsideration

Community Health Choice offers Providers a payment reconsideration process. A payment reconsideration is any claim payment disagreement between the healthcare Provider and Community Health Choice for reason(s) including but not limited to:

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

No action is required by the Member. Provider payment reconsiderations do **not** include Member medical appeals. Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 713.295. 2300 22.

Providers will not be penalized for filing a payment reconsideration request. All information will be confidential.

Complete the Provider Payment Dispute Form which you will find on our website athttps://provider.communityhealthchoice.org/resources/forms-and-guides/ and submit it along with supporting documentation to:

Community Health Choice
Attn: Claims Payment Reconsideration 4888
Loop Central Dr.
Houston, TX 77081

A network or non-network Provider should file a payment appeal within 120 calendar days of the date of the Explanation of Payment (EOP) or for retroactive medical necessity reviews as of the date of the denial letter. The request should

include an explanation of what is being appealed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include:

- Letter stating the reason(s) why the Provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Community Health Choice EOP
- EOP or Explanation of Benefits (EOB) from another carrier
- Evidence of eligibility verification (e.g., a copy of ID card, panel report, the TMHP/TexMedNet documentation, call log record with the date and name of the Community Health Choice person the Provider's staff spoke with when verifying eligibility)
- Medical records
- Approved authorization form from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log, if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was accepted by Community Health Choice; rejection reports are not accepted as proof of timely filing

When submitting a request for payment reconsideration, we recommend Providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications, at least until the request is resolved.

Community Health Choice will research and determine the current status of a request for payment reconsideration. A determination will be made based on the available documentation submitted with the request and a review of Community Health Choice systems, policies, and contracts.

The results of the review will be communicated in a written decision to the Provider within 30 calendar days of the receipt of the appeal. An EOP is used to notify Providers of overturned denied claims or additional payments. An upheld denied claim receives a payment reconsideration determination letter. The determination letter includes the following:

- A statement of the Provider's request
- The reviewer's decision, along with a detailed explanation of the contractual and/or medical basis for such decision
- A description of the evidence or documentation that supports the decision
- A description of the method to obtain a second level internal review
-

If a Provider is dissatisfied with the payment reconsideration resolution, he or she may file a second-level payment reconsideration request . This should be a written request and must be submitted within 30 days of the date of the first- level determination letter. The case is handled by reviewers not involved in the first-level review. Once the request is reviewed, the results are communicated in a written decision to the Provider within 30 calendar days of receipt of the request. An EOP is used to notify Providers of overturned denied claims or additional payments. An upheld denied claim receives a payment determination letter. For a decision in which the denial was upheld, the Provider should review the Participating Provider Agreement for any other available methods of dispute resolution. The Provider may also file a complaint with HHSC or TDI as applicable.

After exhausting Community Health Choice complaint procedures, providers may also file a complaint with HHS by submitting the complaint to:

Texas Health and Human Services
HPM Complaints
P.O. Box 85200, MC H-320
Austin, TX 78758

Questions regarding the Community Health Choice Provider payment dispute process may be directed to Provider Services or a Provider Relations representative.

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 contacted 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, TX 78720-4077

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 Medicaid/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/STAR+PLUS/CHIP/CHIP Perinatal Program or Community Health Choice'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 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 provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:
- "I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."
- "Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsibilidad 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."

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

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

Let us know if you think a doctor, dentist or pharmacist at a drug store, other healthcare Providers, or a person getting benefits is doing something wrong. Doing something wrong could be Fraud, Waste, or Abuse, which is against the law. For example, tell 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 Fraud, Waste, or Abuse, 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 Fraud, Waste, or Abuse" to complete the online form; or
- You can report directly to your health plan:

Community Health Choice
Chief Compliance Officer
4888 Loop Central Dr.
Houston, TX 77081
1.877.888.0002

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

- When reporting about a Provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of Provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the Provider and facility, if you have it
  - Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the Fraud, Waste, or Abuse

Community Health Choice's Special Investigation Unit

Our Special Investigations Unit (SIU) team is responsible for minimizing Community Health Choice's risk to healthcare fraud. The SIU team partners with Community Health Choice's Customer Service Claim Centers and others to help identify suspicious claims, stop payments to fraudulent Providers, and report wrongdoers to the appropriate entity, including but not limited to the Office of Inspector General.

The SIU team also works with state and federal law enforcement and regulatory agencies to detect, prevent, and prosecute healthcare fraud. The SIU team includes trained professionals with expertise in investigations, audits, health care, nursing, and accounting.

Texas Administrative Code, Title 1, Rule §353.502(g) states, "Failure of the provider to supply the records requested by the MCO will result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold."

Code of Federal Regulations, Title 42, Section 424.5(a)(6) states, "Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment."

How to Report Healthcare Fraud to Community Health Choice's SIU

- Call the Compliance hotline at 1.877.888.0002
- Email us: SIU@communityhealthchoice.org
- Write to us:

Community Health Choice Attn:
Special Investigations Unit
4888 Loop Central Dr
Houston, TX 77081

Reporting Abuse, Neglect or Exploitation (ANE)

MEDICAID MANAGED CARE

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 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 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 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.

Providers must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the DFPS.

Health and Human Services (HHS) Hospice Services

HHS 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 HHS 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 Health Choice. Direct questions about the hospice program to the Hospice Program at 1.512.438.3550. Services unrelated to the terminal illness are the responsibility of Community Health Choice.

STAR+PLUS Member Eligibility

STAR+PLUS Member Eligibility

STAR+PLUS Program STAR+PLUS is a Texas Medicaid program integrating the delivery of acute care services and Long- Term Services and Supports (LTSS) to Medicaid recipients who are aged, blind and disabled, through a managed care system. The STAR+PLUS program is designed to assist Medicaid recipients with chronic and complex conditions who require more than acute care services.

The STAR+PLUS program operates under the federal Medicaid waiver Home and Community-Based Services in order to mandate participation and to provide Home and Community-Based Services. HHS is the oversight agency for the STAR+PLUS program.

Mandatory Members

The following Medicaid-eligible individuals MUST enroll in the STAR+PLUS program:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS (c) waiver eligibility.
- Dual eligible individuals who are 21 and over covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a Nursing Facility.

Voluntary Members

The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:

- Nursing Facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing Facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE).

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

- Nursing Facility residents who reside in the Truman W. Smith Children's Care Center or reside in a state veterans home.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Residents of Institutions of Mental Disease or State Hospitals.
- Children in the conservatorship of the Texas Department of Family and Protective Services (DFPS).
- Dual eligible (individuals who have both Medicare and Medicaid) who are residents of Intermediate Care. Facilities for Persons with IID (ICF/IID) Community Living Assistance and Support Services.
- Persons enrolled in a waiver program other than the HCBS STAR+PLUS(c) Nursing Facility waiver program.
- Individuals not eligible for full Medicaid benefits (e.g., frail elderly program, Qualified Medicare Beneficiary [QMB], Service Limited Medicare Beneficiary [SLMB], Qualified Disabled Working Individual [QDWI], undocumented immigrants).
- Individuals receiving long-term care services through non-Medicaid funded programs

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.

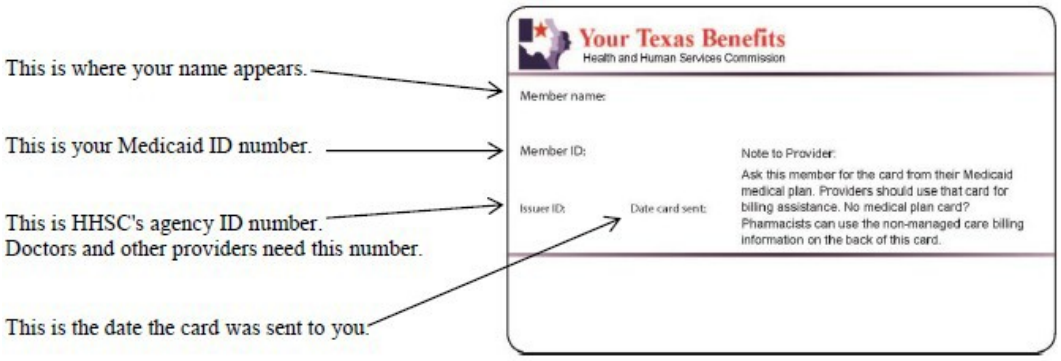
Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the Member has current Medicaid coverage. A provider should verify the Member's eligibility for the date of service before rendering services. There are multiple ways to do this:

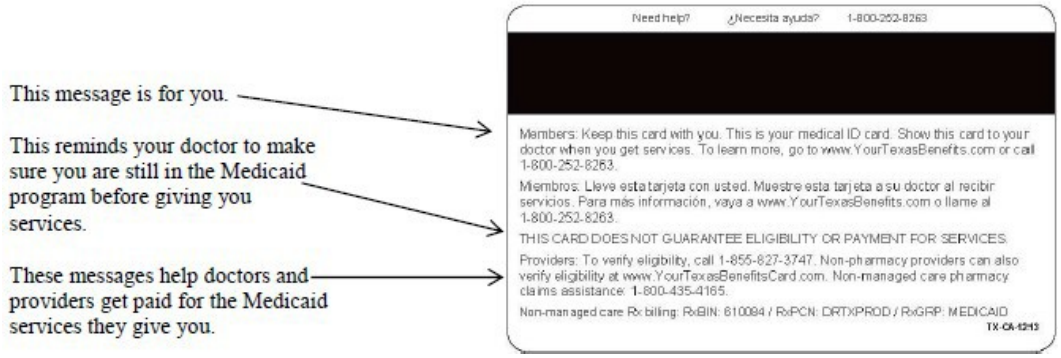
- Call Community Health Choice or check MCO Provider Portal.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and accessing Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- Your Texas Benefits Medicaid Card
    - Temporary ID (Form 1027-A)
    - Community Health Choice ID Card
        - STAR+PLUS Dual Eligible - If the Member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's MCO ID card. The Member receives long-term services and supports through Community Health Choice.

Texas Benefits Medicaid Card

Front of the card:



Back of the card:



Verifying Community Health Choice Member Eligibility

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

When verifying Member eligibility, ask for your patient's Community Health Choice 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 Health Choice. To verify Community Health Choice Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community Health Choice Online at CommunityHealthChoice.org. Complete the Community Health Choice Secure Access Application to become an authorized user.
- Call Community Health Choice Member Services to get more information.
- Community Health Choice Provider Services at 713.295. 2300 or 1.888.435.2850 . You can check eligibility, benefits and PCP selection.
- Providers may also contact the TMHP Automated Inquiry System (AIS) at 1.800.925.9126 and by visiting TexMedConnect Provider portal on the TMHP website at TMHP.com.
- 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 Health Choice Online:
    - Member's name
    - Member's ID number
    - Member's designated PCP

Community Health Choice Member ID Card

When a Community Health Choice Member visits your office, make a copy of both sides of their Community Health Choice Member ID Card and the Your Texas Benefit Medicaid Card. Please note that although the Community Health Choice Member ID Card identifies a Community Health Choice Member, it does not confirm eligibility or guarantee eligibility for benefits coverage or payment. If the Member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services; therefore, the PCP's name, address, and telephone number are not listed on the Member's ID card.

The Community Health Choice Member ID Card contains the following information:

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

CHC STAR+PLUS DUAL ID CARD

CHC STAR+PLUS NON-DUAL ID CARD

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. 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

STAR, CHIP, and STAR+PLUS Medicaid only (not Medicare dual Members) are given the option of selecting a health plan and a PCP. If a Member does not select a PCP, Community Health Choice will auto-assign a PCP, taking into consideration any prior Member/ Provider relationships and the Member's home address. Members may change their PCP at any time, if those changes are made over the phone with Member Services, the change is immediate. If the change is requested over the website, it will go into effect in approximately 24 hours. Limitations to Member selecting a specific PCP could include:

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

STAR+PLUS Members who are dually eligible for Medicare will receive their PCP selection through Medicare.

STAR+PLUS Value-Added Services

Community Health Choice offers Value-Added Services to our STAR+PLUS Members to enhance the value of our managed care product. Value-added services can change by contract year, so please refer to Community Health Choice's website or contact Community Health Choice directly for a current list.

- Extra Help with Getting a Ride: Community Health Choice will provide additional transportation for members and family member/caregiver to appointments outside of the covered NEMT benefit, at no cost to STAR+PLUS Members as determined by Community.
- Extra Dental Benefits for Members 21 and older: Members age 21 and over receive up to $600 annually, towards two (2) routine dental exams per year with teeth cleaning, x-rays (once annually), non-surgical extractions and emergency exams (limited) at no cost. All additional services above and beyond those listed in this paragraph are provided to the member at a 25% discount
- Extra Vision Services: Eligible members may elect to opt-out of the standard eyewear benefit and utilize $150 to use toward the purchase of non-standard eyeglasses OR **contact** lenses, including disposables and contact lens fitting fees every twenty-four (24) months, with the benefit period measured from the date of service. This is a total eyewear allowance that may be applied to the Member's choice of eyeglass frame/lenses/lens options or to contact lenses in lieu of eyeglasses. Eyewear must have a prescription of at least + 0.50 diopter in at least one eye to qualify for coverage. Members who elect to purchase eyewear with a retail value greater than the $150 allowance are financially responsible for paying the participating provider's usual and customary (retail) cost of the difference between the cost of the eyewear selected and the $150 allowance.
- Discount Pharmacy/Over-the-Counter Benefits: Members receive $30 per quarter (up to $120 annually) for over-the-counter-medicines and other health related supplies not covered by Medicaid.
- Help for Members with Asthma: Community Health Choice will offer educational materials and will provide an Allergy-free mattress cover and pillowcase for members who are enrolled in Community's Disease Management/Case Management Program. Member gets one Allergy-free mattress cover and pillowcase annually.
- Extra Help for Pregnant Women: Mom Community Rewards is for pregnant women. Members receive a $25 gift card for completing a prenatal checkup within 42 days of enrollment and a $25 gift card for completing a timely postpartum checkup within 21- 84 days after giving birth.Through Mom Community Rewards, members can also access health education materials through their Community Health Choice My Member Account.
- Health and Wellness Services: Community Health Choice will provide Home delivered meals for one week after getting out of the hospital for STAR+PLUS non-waiver Members. Member may receive up to 7 meals after admission/discharge from inpatient facility.

- Home Visits: Community will provide the following additional in-home visits:
  - Respite Services, up to 16 hours, annually, for STAR+PLUS non-waiver community-based Members
- Home Visits: Community will provide the following additional in-home visits:
  - Companionship Visits, up to 48 hours, annually, for STAR+PLUS non-waiver community-based Members
- Health and Wellness Services: Community Health Choice will provide Home delivered meals for one week after getting out of the hospital for STAR+PLUS non-waiver Members. Member may receive up to 7 meals after admission/discharge from inpatient facility.
- Health and Wellness Services: Community will provide access to a nutritionist to provide personalized and culturally sensitive education for dietary needs and weight management and/or loss.
- Health and Wellness Services: Community Health Choice will provide access to online resources, to connect with free or low-cost community resources to address food, housing, economic and educational insecurities.
- Health and Wellness Services: Community Health Choice will provide one pill organizer for community-based members.
- Health and Wellness Services: Community Health Choice will provide one blanket to each STAR+PLUS Nursing Facility Member.
- Health and Wellness Services: Community Health Choice will provide one digital, large print clock for each newly enrolled STAR+PLUS Nursing Facility member.
- Health and Wellness Services: Community Health Choice will provide one pair non-skid socks each STAR+PLUS Nursing Facility Member.
- Healthy Play and Exercise: All Community Health Choice STAR+PLUS community-based members are eligible to join participating Baker Ripley centers in their area at no cost to the Member. Baker Ripley provides adult education, activity, and resources to promote physical, mental and spiritual wellness.
- Healthy Play and Exercise: Community Health Choice will provide an exercise/fitness kit, (which may include a resistance band, hand weight and pedometer) for all STAR+PLUS Nursing Facility members.
- Gift Programs: Community will provide incentives for achieving health targets for management of diabetes, schizophrenia, bipolar disorder and recommended yearly screenings as follows:

  $85 gift card for diabetic members who get an HbA1c blood test every 6 months

  $30 gift card for diabetic members who get a diabetic eye exam each year

  $30 Gift card for members with schizophrenia or bipolar disorder who are using antipsychotic medications and received a diabetes screening

  $30 gift card each year for current female members who get a recommended mammogram.

- Behavioral Health – Online Mental Health Resources: Community will provide online mental telehealth resources for all STAR+PLUS Members.
- Behavioral Health – Online Mental Health Resources: Community will provide an online companionship tool for all STAR+PLUS Members.
- Behavioral Health – Online Mental Health Resources: Community Health Choice will provide a virtual mental health intensive outpatient program that offers online individual and group therapy services, aftercare services and medication management for STAR+PLUS community-based Members.

STAR+PLUS Member Rights and Responsibilities

STAR+PLUS Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect
    b. Know that your medical records and discussions with your Providers will be kept private and confidential
2. You have the right to a reasonable opportunity to choose a health care plan and PCP. This is the doctor or health care Provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your PCP
    b. Choose any health plan you want that is available in your area and choose your PCP from that plan
    c. Change your PCP
    d. Change your health plan without penalty
    e. Be told how to change your health plan or your PCP
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your Provider explain your healthcare needs to you and talk to you about the different ways your healthcare problems can be treated
    b. Be told why care or services were denied and not given
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your Provider in deciding what health care is best for you
    b. Say yes or no to the care recommended by your Provider
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need
    b. Get medical care in a timely manner
    c. Be able to get in and out of a health care Provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

d. Have interpreters, if needed, during appointments with your Providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability or help you understand the information.

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member's Right to Designate An OB/GYN

Community Health Choice allows the Member to pick an 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 PCP. 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 a specialist doctor within the network

STAR+PLUS Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program
    b. Ask questions if you do not understand your rights
    c. Learn what choices of health plans are available in your area
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules
    b. Choose your health plan and a PCP quickly
    c. Make any changes in your health plan and PCP in the ways established by Medicaid and by the health plan
    d. Keep your scheduled appointments
    e. Cancel appointments in advance when you cannot keep them
    f. Always contact your PCP first for your non-emergency medical needs
    g. Be sure you have approval from your PCP before going to a specialist
    h. Understand when you should and should not go to the emergency room
3. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:

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

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your Provider in deciding what health care is best for you
    b. Understand how the things you do can affect your health
    c. Do the best you can to stay healthy
    d. Treat Providers and staff with respect
    e. Talk to your Provider about all of your medications

Additional Member Responsibilities while using NEMT Services:

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

Billing Members

Medicaid Providers are prohibited from billing Medicaid recipients unless certain conditions are met as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM). Providers may NOT request payments from Community Health Choice STAR Members. There are no co-payments for Medicaid Members who are Native Americans or Alaskan Natives. Community Health Choice STAR and STAR+PLUS Members cannot be billed for any services covered by either the STAR or STAR+PLUS program or Community Health Choice. (1 TAC 15 354.1005)

Complaints & Appeals

STAR+PLUS Member Complaint Process

How to File a Complaint

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

Community Health Choice
Service Improvement 4888
Loop Central Dr Houston, TX
77081
Or by calling Community Health Choice toll free at 1.888.435.2850 .

Once a Member has gone through the Community Health Choice 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
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247
If you can get on the Internet, you can submit your complaint at:
hhs.texas.gov/managed-care-help

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.

Long-Term Care (LTC) Ombudsman

The LTC Ombudsman identifies, investigates, and resolves complaints that adversely affect the health, safety, welfare or rights of people who live in nursing facilities and assisted living facilities to ensure they receive optimal quality of care and achieve high quality of life. STAR+PLUS members can file a complaint through the Office of Long-Term Care Ombudsman.

Contact information:
• The Office of the LTC Ombudsman can be contacted at 1-800-252-2412.
• LTC Ombudsman website: https://apps.hhs.texas.gov/news_info/ombudsman/
• A list and contact information of the 28 Area Agencies on Aging can be found at:
https://apps.hhs.texas.gov/contact/aaa.cfm

Requirements and Time Frames for Filing a Complaint

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

Can someone from Community Health Choice help my Member file a complaint, appeal or expedited appeal?

If a Community Health Choice Member needs assistance filing a complaint, appeal or expedited appeal, they may call Community Health Choice Member Services at 713.295. 2300 or 1.888. 435.2850 , and a Community Health Choice Member Advocate will assist them.

Community Health Choice will notify the Provider and Member when it issues as Adverse Determination.

What can I do if Community Health Choice 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 Health Choice that do not meet the criteria of medical necessity that is deemed experimental or investigational. 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.

Member Appeal Process

How to File an Appeal

Members, or their authorized representative, have the right to file an oral or written appeal. Submit appeals to:

Community Health Choice
Member Appeals Coordinator
4888 Loop Central Dr
Houston, TX 77081

Phone 713.295.2300 or 1.888.435.2850
Fax: 713.295.7033

Community Health Choice Attn:
Behavioral Health Appeals
P.O. Box 1411
Houston, TX 77230
Fax: 713.576.0934 (Standard Requests)
Fax: 713.576.0935 (Expedited Requests)

If a Member files a written appeal, Community Health Choice will send the requestor a written acknowledgement within five business days. If a Member files an oral appeal, Community Health Choice will send a written acknowledgement and an Appeal Form within five business days. The requestor 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 Health Choice 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.

Time Frame 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 Health Choice's mailing and notice of the action or (2) the intended effective date of the

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

Time Frame for Resolution of an Appeal

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

How will I find out if services are denied?

If Community Health Choices denies services, we will send you a letter at the same time the denial is made.

When can a Member request a State Fair Hearing?

Members must go through the appeal process before requesting a State Fair Hearing. 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 4888
Loop Central Dr
Houston, TX 77081
Phone:
Phone: 713.295.2300 or 1.888.435.2850
Fax: 713.295.7033

Community Health Choice 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. An acknowledgement of the expedited appeal will be communicated to the requestor on the next business day.

Resolution Time Frame for an Expedited Appeal

Community Health Choice 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 Health Choice receives the request for the expedited appeal.

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

1) the Member requests an extension; or
2) Community Health Choice advises the Member of a need for additional information and that extending the time frame may be in the Member's best interest.

Community Health Choice will provide written notice of the reason for a delay, if the Member had not requested the delay.

What if Community Health Choice denies the request for an Expedited Appeal?

If Community Health Choice determines that an appeal request does not follow the criteria of an Expedited Appeal, it will be considered and processed as a standard appeal. Community Health Choice shall make a reasonable effort to notify the requestor that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

External Medical Review Information

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Community Health Choice by using the address or fax number at the top of the form.;
- Call Community Health Choice at 713.295.2300 or toll-free at 1.888.435.2850
- Email Community Health Choice at Appeals@communityhealthchoice.org, or;

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

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An

External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

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

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Community Health Choice. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete Community Health Choice's internal appeals process.

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent 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 the Member's representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 Days of the date on the health plan's letter with the decision. If the Member does not ask for the State Fair Hearing within 120 Days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at:

Community Health Choice Attn:
Member Appeals Coordinator
4888 Loop Central Dr- Houston, TX 77081
Or call Toll Free at 1.888.435.2850

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

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

HHSC will give the Member a final decision within 90 Days from the date the Member asked for the State Fair Hearing.

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

Community Health Choice will assist members with accessing programs such as the Texas agency administered programs and case management services, and essential public health services. These non-capitated services are not included in the NF Unit Rate nor are they part of the Nursing Facility Add-On services. The Texas Medicaid Provider Procedures Manual includes a complete list of carve-out services for STAR+PLUS.

The Service Coordinator will work with NF staff to refer members to obtain services as described in the Texas Medicaid Provider Procedures Manual (TMPPM) including the following services:

- Effective January 1, 2017, NorthSTAR will be discontinued and MCOs in the Dallas Service Area will be responsible for Medicaid Behavioral Health Services and MMP Behavioral Health Services consistent with all over Service Areas. (See Chapter 4 Behavioral Health Services for more information)
- Providers must coordinate with the local tuberculosis control program to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy by a DSHS-approved provider. The Provider must report to DSHS or the local Tuberculosis control program any Member who is non-compliant, drug resistant, or who is or may be posing a public threat.
- Hospices services provided by Home and Community Support Service Agencies contracted with the Department of Aging and Disability Services.
- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative serviced and targeted case management. Specialized serviced provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy and customized adaptive aids. All PASRR specialized services are non-capitated, fee-for-service.
- Long Term Care services and supports for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers.