WELCOME TO COMMUNITY HEALTH CHOICE

STAR + PLUS

Presented by: Brandi Robinson & Robbie Nixon

INTRODUCTION

•Welcome to Community Health Choice We are excited to serve you! Community Health Choice is a local, non-profit, Managed Care Organization (MCO) with a mission to improve the health and well-being of Texas residents throughout Harris county. As a Community Health Choice Member, we want to make sure that you have access to information and services you need to get started. Here are a few reminders:

• If you have special needs, have trouble seeing or speak another language, please call our Member Services Department toll-free at 1.888.435.2850.

• We will send you this information in a way that you can read it. If you need an interpreter to help you understand this handbook, we can provide you oral or written interpreter help. If you need help with sign language, Community offers Sign Share. If you have trouble hearing or speaking, please call the TTY/TDD line at 7-1-1 or toll-free at 1.800.735.2989.

• If you need auxiliary aids and services, including getting materials in alternative formats like large print or Braille, please call the HHSC Eligibility Office toll-free at 1.855.827.3748 or our Member Services Department toll-free at 1.888.435.2850. Community is committed to assisting our Members. We provide 24-hour access through toll-free phone numbers to connect directly to our Member hotline, Behavioral Health (BH) Non-Crisis hotline, BH Crisis hotline, Service Coordination hotline and the Non-Emergency Medical Transportation (NEMT) services hotline. To reach our Member Service staff call 8:00 a.m. - 5:00 p.m., Monday – Friday, excluding state-approved holidays. Access your My Member Account online 24 hours a day, seven days a week

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

Star +Plus Program

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.

Star + Plus Program

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.

Star + Plus Program

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

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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 PROVIDER MANUAL

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

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.

PROVIDER RESPONSIBILITIES

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.

SERVICE COORDINATOR

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.

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.

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.

PROVIDER PORTAL

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.

AUTHORIZATIONS

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.

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.

OTHER SERVICES

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.

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**.

BILLING AND CLAIMS

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.

WAYS TO SUBMIT CLAIMS

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.

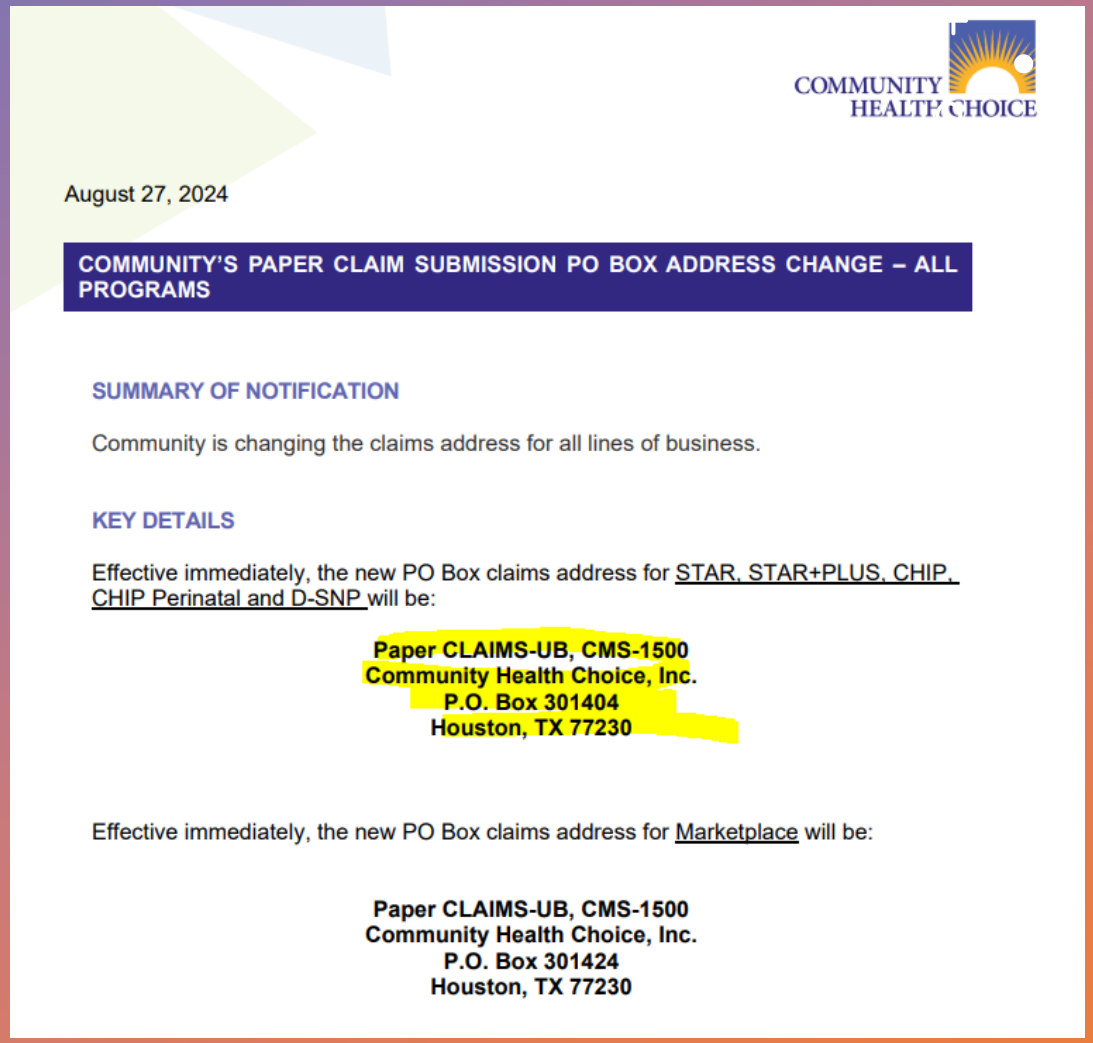
After logging in, select "Submit Claim (Medicaid/CHIP)" on the Secured Pages option to access the claim submission page. If you do not have permission to access the page, please contact your administrator to request permission.

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:

SUBMITTING CLAIMS BY MAIL



COMMUNITY HEALTH CHOICE

August 27, 2024

COMMUNITY'S PAPER CLAIM SUBMISSION PO BOX ADDRESS CHANGE – ALL PROGRAMS

SUMMARY OF NOTIFICATION

Community is changing the claims address for all lines of business.

KEY DETAILS

Effective immediately, the new PO Box claims address for STAR, STAR+PLUS, CHIP, CHIP Perinatal and D-SNP will be:

Paper CLAIMS-UB, CMS-1500
Community Health Choice, Inc.
P.O. Box 301404
Houston, TX 77230

Effective immediately, the new PO Box claims address for Marketplace will be:

Paper CLAIMS-UB, CMS-1500
Community Health Choice, Inc.
P.O. Box 301424
Houston, TX 77230

CLAIM PAYMENTS

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.

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

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.

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.

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.

COMMUNITY HEALTH CHOICE MEMBER ID CARD

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.

SKILLED NURSING FACILITY CONTACTS

- Brandi Robinson; Provider Performance Manager
- Email: Brandi.Robinson@CommunityHealthChoice.org
- Phone: 713-295-2308

- Robbie Nixon; Provider Performance Manager
- Email: Robbie.Nixon@CommunityHealthChoice.org
- Phone: 713-295-2245