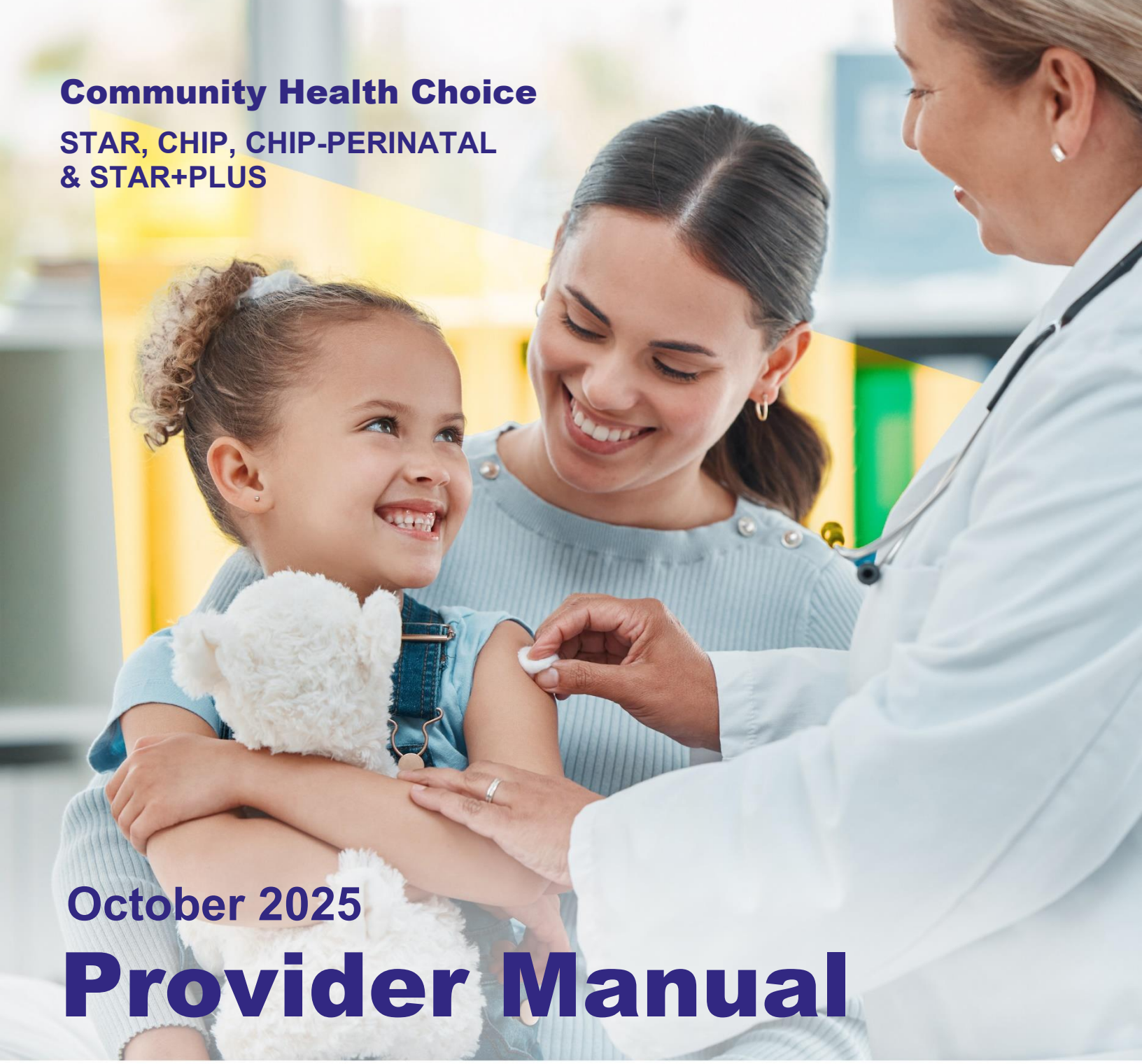

Community Health Choice

STAR, CHIP, CHIP-PERINATAL & STAR+PLUS

October 2025

Provider Manual

Harris Service Area

Provider Services
Local: 713.295.2300
Toll Free: 1.888.435.2850
Website: Provider.CommunityHealthChoice.org

TEXAS Health and Human Services | CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR PLUS Your Health Plan ★ Your Choice

COMMUNITY HEALTH CHOICE

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QUICK REFERENCE INFORMATION

Provider Services	For general questions or to submit your updates: Phone: 713.295.2300 Toll Free: 1.888.435.2850 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: 713.295.2300 Toll Free: 1.888.435.2850 • Benefit Coverage and Eligibility Verification • Physician Information • Service Questions • Interpreter Services • Specialist Referral Assistance
Claims Inquiries or Adjudication	CommunityHealthChoice.org Phone: 713.295.2300 Toll Free: 1.888.435.2850 Community Health Choice will accommodate three claims per call. Unlimited inquiries on website
Utilization Management (Medical)	Phone: 713.295.2300 Fax: 713.295.2283 (CHIP/STAR outpatient) Fax: 713.848.6957 (STAR+PLUS) Fax: 713.295.2284 (Notice of Admission) Fax: 713.295.7030 (Inpatient Clinicals) Fax: 713.295.7016 (Transplant) Fax: 713.576.0937 (Retrospective) Fax: 713.295.2319 (Peer-to-Peer)
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: 713.295.2300 Fax: 713.576.0933 E-mail: BHCasemanagementreferrals@CommunityHealthChoice.org
Report High Risk Pregnancy or Sick Newborn	Phone: 713.295.2300 Toll Free: 1.888.435.2850 Fax: 713.295.7028
Peer-to-Peer Discussions	Phone: 713.295.2319
Diabetic Supplies	Phone: 713.295.2300 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 301404 Houston, TX 77230
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 • Optum Change HealthCare Solutions, Inc. • 1.877.469.3263 • TMHP (STAR and STAR+PLUS only) TMHP.com
Adverse Determination and Appeals (Medical)	Community Health Choice Attn: Medical Appeals 4888 Loop Central Dr. Houston, TX 77081 Fax: 713.295.7033

	All appeals must be in writing and accompanied by medical records.
Adverse Determination and Appeals (Behavioral Health)	Community Health Choice Attn: Behavioral Health Appeals P.O. Box 1411 Houston, TX 77230 Fax: 713.576.0934 (Standard Appeal Requests) Fax: 713.576.0935 (Expedited Appeal Requests) All appeals must be in writing and accompanied by medical records.
Behavioral Health	Toll Free: 1.877.343.3108
Dental Services	**For STAR+ PLUS Members (Value Added)** FCL Dental: 1.866.844.4251
Lab	Members can go to any of these preferred laboratories: • Clinical Pathology Laboratories, Inc. • LabCorp • Quest Diagnostics
Pharmacy	Navitus Health Solutions 1.877.908.6023 | Navitus.com
Vision Services	Envolve Vision **For STAR + PLUS Members** Customer Service (Member Eligibility and Claims Inquires): 844.686.4358 Network Management (Provider Participation): 1.800.531.2818
Early Childhood Intervention (ECI)	Toll Free: 1.877.787.8999
Non-Emergency Medical Transportation (NEMT)	**For STAR Members** Access2Care: 844.572.8194 Members can also schedule NEMT through the Access2Care (A2C) Member app. App available via app store. **For STAR+PLUS Members** Access2Care: 844.572.8194 Members can also schedule NEMT through the Access2Care (A2C) Member app. App available via app store.

Enrollment/Disenrollment Medicaid and CHIP	Toll Free: 1.800.252.8263 2-1-1 YourTexasBenefits.com
File a Complaint	Community Health Choice Attn: Service Improvement 4888 Loop Central Dr. Houston, TX 77081 Phone 1.888.435.2850 Fax: 713.295.7036 (STAR+ PLUS) ServiceImprovement@CommunityHealthChoice.org
Health and Human Services Office of the Ombudsman	Toll Free: 1.866.566.8989

Introduction

About Community Health Choice

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

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

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

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

Our Mission Statement

To improve the health and well-being of all Texans, particularly the underserved, by opening doors to healthcare and health-related services.

Our Culture Statement

We empower and equip all employees to make a meaningful difference in the lives of our members and our community, at large, by fostering a workplace environment of mutual trust, transparency, inclusivity, innovation, accountability, and compassion for everyone by everyone.

Our Core Values

Our team members are trustworthy, caring individuals who are collaborative with our Members, Providers, and community partners. We are innovative and display accountability as we serve Members and the community

Community Health Choice Service Areas

Harris Service Area:

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

Using the Provider Manual

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

- Researching details of STAR, STAR+PLUS, CHIP, and CHIP Perinatal programs
- Obtaining prior authorizations for services
- Submitting corrected claims
- Appealing adverse determinations

Material in this Provider Manual is subject to change. The most recent information is also available on our website at CommunityHealthChoice.org. Updates and new services may be added periodically to the Provider Manual as required by law, rule or regulation. Community Health Choice will distribute a copy of the new policy, procedure or guideline upon request.

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

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

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

Code of Ethics

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

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

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

Health Insurance Portability and Accountability Act (HIPAA) of 1996 Electronic Code Sets and Standard Transactions

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

Privacy and Security Statement

As covered entities under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its associated regulations, Community Health Choice and all Providers and clearinghouses must

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

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

Community's Commitment to Providers

Provider Credentialing and Recredentialing

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

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

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

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

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

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

CAQH ProView

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

CAQH-Approved Provider Types

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

- **Standard:** Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)
- **Allied:** Acupuncturist (ACU), Audiologist (AUD), Alcohol/Drug Counselor (ADC), Biofeedback Technician (BT), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Professional Counselor (PC), Licensed Practical Nurse (LPN), Massage Therapist (MT), Marriage/Family Therapist (MFT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optometrist (OD), Optician (OPT), Dietician (DT), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP), Pharmacist (PHA), Physician Assistant (PA), Physical Therapist (PT)
- **Note:** It may be necessary for Community Health Choice to contact you to supplement, clarify or confirm certain information submitted on your CAQH application.

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

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

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

4. Community ensures that Members receive timely and appropriate access to all levels of care, emergent, urgent, routine, and preventive, within specifically defined timeframes.
    a. PCPs within 10 miles or 15 minutes
    b. OB/GYN within 30 miles or 45 minutes
    c. Pre-natal care within 10 miles or 15 minutes
    d. Outpatient Behavioral Health Service Providers within 30 miles or 45 minutes
    e. Specialist Providers (cardiology/cardiovascular diseases, ophthalmology, and orthopedics/orthopedic surgery within 20 miles or 30 minutes; urology and psychiatry within 30 miles or 45 minutes; otolaryngology and all others not otherwise listed) within

30 miles or 45 minutes

f. Occupational and Speech Therapy (outpatient or clinical facility) within 30 miles or 45 minutes

g. cute care hospital within 30 miles or 45 minutes

h. In urban counties, at least 80% of Members must have access to a network pharmacy within 2 miles of Members' residence

i. All other services: specialists not previously referenced, oncology including surgical and radiation, specialty hospitals, psychiatric hospitals, diagnostic services, and single or limited service healthcare physicians or Providers within 75 miles.

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

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

To facilitate the efficient credentialing of physicians and other Provider types while ensuring delivery of quality care, Community may elect to delegate the credentialing process to groups of providers. Prior to delegating the credentialing process, Community establishes clear guidelines that specifically outline the responsibility, accountability, and oversight of the delegated contractor and Community in order to maintain compliance with accreditation standards including NCQA, URAC, and other regulatory requirements.

Initial Credentialing

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

Application attesting to the following and verified via approved primary sources as applicable:

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

Institutional (facility) Providers are required to complete a common facility application generated and approved by the TAHP for use by health plans and the statewide CVO. The Providers must attest to the accuracy of the information provided and authorize the CVO to conduct primary source verification, at minimum, of the following:

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

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

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

Upon completion of the primary source verification process, the CVO will submit completed files to Community for review by the Medical Care Management Committee (MCMC). This credentialing and peer review committee is chaired by Community's Chief Medical Director and is comprised of primary care and specialist physicians who are contracted and credentialed in Community's network. The MCMC meets on a monthly basis and makes the final decision regarding all Providers applying to the network.

Community notifies Providers of the committee's decision within 10 business days and are loaded into the claims payment system no later than 90 days after receipt of the completed application.

Recredentialing

Community implements its policies and procedures for re-credentialing acute care physicians, individual practitioners, and institutional providers, at minimum, every three years in order to re- verify credentialing information and assess performance for the previous three-year period.

Similar to the initial credentialing, this process also includes obtaining a signed and dated application and updating information obtained in the initial credentialing process.

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

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

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

Provider Participation Criteria

Community Health Choice maintains Provider participation criteria for physicians, facility, ancillary, LTSS providers and urgent care providers.

Physician Participation Criteria

The following Participation Criteria applies to all physicians participating in Community Health Choice's Provider network(s), subject to exception based on Community Health Choice's sole discretion; e.g., unique geographic or demographic circumstances or specific Member access and availability needs. Please be aware of the physician participation criteria in the event you are in the process of recruiting additional practitioners to your practice.
Community Health Choice may exclude physicians from participation if they do not meet the physician participation criteria.

Criteria Type	Criteria	Medicaid	CHIP / CHIP P	STAR+PLUS	Additional Notes
Regulatory	Participation in THSteps	Yes	N/A	N/A	Applies to PCP Providers only
	Participation in Wellness	N/A	Yes	N/A	Applies to PCP Providers only
	Participation in the Texas Vaccines for Children Program (TVFC)	Yes	Yes	N/A	
	Attested NPI Number (required)	Yes	Yes	Yes	
	Medicare Number (preferred)	Yes	Yes	No	Does not apply to pediatric or OB/GYN Providers
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	
	Not currently on Govt. Exclusion List	Yes	Yes	Yes	
Administrative	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes	
	Facsimile	Yes	Yes	Yes	
	Hospital Privileges at Participating Hospital or Surgery Center	Yes	Yes	Yes	Or advanced approval of acceptable coverage (e.g., hospitalist or designation)
	Submission of authorization requests via Provider Portal	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Through existing clearinghouse partnerships
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	

	Adherence to HIPAA Standard Transactions	Yes	Yes	Yes	
	Participation in CAQH program	Yes	Yes	Yes	
	Electronic Medical Record (EMR)	Yes	Yes	Yes	

Ancillary Participation Criteria

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

Criteria Type	Criteria	Medicare	CHIP / CHIP P	STAR+PLUS	Additional Notes
Administrative	Valid Texas Medicaid Number (required)	Yes	Yes	Yes	
	Valid Medicare Number (required)	Yes	No	No	
	At least one line dedicated for facsimile	Yes	Yes	Yes	
	Submission of authorization requests via Provider Portal	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Through existing clearinghouse partnerships
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	
	Electronic Medical Record (EMR)	Yes	Yes	Yes	
Regulatory	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	

Urgent Care Participation Criteria

The following Participation Criteria applies to all Urgent Care Providers in Community Health Choice's Provider network(s), subject to exception based on Community Health Choice's sole discretion; e.g., unique geographic or demographic circumstances or specific Member access and availability needs.

Criteria Type	Criteria	Medicaid	CHIP / CHIP P	STAR+PLUS	Additional Notes
Administrative	Has valid Texas Medicaid Number	Yes	Yes	Yes	

Criteria Type	Criteria	Medicaid	CHIP / CHIP P	STAR+PLUS	Additional Notes
	Has valid Medicare Number	Yes	Yes	Yes	
	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes	
	Facsimile	Yes	Yes	Yes	
	Electronic Medical Record (EMR)	Yes	Yes	Yes	
	Electronic submission of prescriptions (e-Prescribe)	Yes	Yes	Yes	
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Through existing clearinghouse partnerships
	EDI - Electronic Funds Transfer	Yes	Yes	Yes	
	EDI - Electronic Remittance Advice	Yes	Yes	Yes	
	Visit summary to PCP within 24 hours or next business day	Yes	Yes	Yes	
	Adherence to HIPAA Standard Transactions	Yes	Yes	Yes	
	Accreditation - Urgent Care Association of America (UCAOA)	Yes	Yes	Yes	
	Certification - Certified Urgent Care (CUC) Program	Yes	Yes	Yes	

Criteria Type	Criteria	Medicaid	CHIP / CHIP P	STAR+PLUS	Additional Notes
	Electronic submission of prescriptions (e-Prescribe)	Yes	Yes	Yes	
Quality	Onsite services (i.e., lab, x-ray, etc.)	Yes	Yes	Yes	

LTSS HCBS Provider Requirements

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
PAS	The Provider must be licensed by the State as a HCSSA. The level of licensure required depends on the type of service delivered. An agency may have only the PAS level of licensure. If the Member
	uses the CDS option, the Provider must meet the requirements outlined in the 1115 demonstration project.
Employment Assistance	The Provider must meet all of the criteria in one of these three options. Option 1: 1. A bachelor's degree in rehabilitation, business, marketing, or a related human services field; and 2. Six months of documented experience providing services to people with Disabilities in a professional or personal setting. Option 2: 1. An associate's degree in rehabilitation, business, marketing, or a related human services field; and 2. One year of documented experience providing services to people with Disabilities in a professional or personal setting. Option 3: 1. A high school diploma or GED; and Two years of documented experience providing services to people with Disabilities in a professional or personal setting.
Supported Employment	The Provider must meet all of the criteria in one of these three options. Option 1: 1. A bachelor's degree in rehabilitation, business, marketing, or a related human services field; and 2. Six months of documented experience providing services to people with Disabilities in a professional or personal setting.

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
	Option 2: 1. An associate's degree in rehabilitation, business, marketing, or a related human services field; and 2. One year of documented experience providing services to people with Disabilities in a professional or personal setting. Option 3: 1. A high school diploma or GED; and Two years of documented experience providing services to people with Disabilities in a professional or personal setting.
Assisted Living Services	The Provider must be licensed by HHSC's Long Term Care Regulatory Division in accordance with 26 Tex. Admin. Code ch. 553. The type of licensure determines what services may be provided.
Nursing Services	The Provider must be a licensed RN by the Texas Board of Nursing under 22 Tex. Admin. Code ch. 217.
Cognitive Rehabilitation Therapy	Psychologist must be licensed under Tex. Occ. Code ch. 501. Speech and language pathologists must be licensed under Tex. Occ. Code ch. 401. Occupational therapist must be licensed under Tex. Occ. Code ch. 454.
Adult Foster Care	Adult Foster Care (AFC) homes must meet the standards described in **Exhibit E**. AFC homes including the Member's home must either have been determined qualified based on the standards or licensed by HHSC under 26 Tex. Admin. Code ch. 553, for homes serving four or more residents. The MCO must demonstrate the ability to recruit, train, and certify AFC Providers based on standards referenced above either in-house or through an AFC-agency Provider.
Support Consultation	The Provider must complete HHSC required training and receive a certificate of completion from HHSC.
Dental	The Provider must be licensed by the Texas State Board of Dental Examiners as a Dentist under 22 Tex. Admin. Code ch. 101.
Respite Care	The Provider must be licensed by HHSC as a HCSSA under 26 Tex. Admin. Code ch. 558; licensed as a NF Provider under 26 Tex. Admin. Code ch. 554; licensed by HHSC as an Assisted Living provider under 26 Tex. Admin. Code ch. 553; or AFC provider licensed by HHSC under 26 Tex. Admin. Code ch. 553. Unlicensed AFC providers must meet the qualifications described in **Exhibit E.** AFC homes serving four or more participants must be licensed by HHSC under 26 Tex. Admin. Code ch. 553.
Home Delivered Meals	The Provider must comply with requirements for providing home delivered meal services in accordance with 40 Tex. Admin. Code ch. 55.
Physical Therapy	The Provider must be a licensed physical therapist through the Texas Board of

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
Services	Physical Therapy Examiners, Tex. Occ. Code ch. 453.
Occupational Therapy Services	The Provider must be a licensed occupational therapist through the Texas Board of Occupational Therapy Examiners, Tex. Occ. Code ch. 454.
Speech, Hearing, and Language Therapy Services	The Provider must be a licensed speech therapist through the Texas Department of Licensing and Regulation under 16 Tex. Admin. Code Part 4 Chapter 111.
Financial Management Services	The Provider must complete initial and ongoing HHSC-required training and receive a certificate of completion of training. FMSAs must be eligible to contract with HHSC to contract with an MCO.
Transition Assistance Services	The Provider must comply with the requirements for delivery of TAS. TAS Providers must demonstrate knowledge of, and experience in, successfully serving Members who require home and Community-Based Services.
Dental	The Provider must be licensed by the Texas State Board of Dental Examiners as a Dentist under 22 Tex. Admin. Code ch. 101.
Respite Care	The Provider must be licensed by HHSC as a HCSSA under 26 Tex. Admin. Code ch. 558; licensed as a NF Provider under 26 Tex. Admin. Code ch. 554; licensed by HHSC as an Assisted Living provider under 26 Tex. Admin. Code ch. 553; or AFC provider licensed by HHSC under 26 Tex. Admin. Code ch. 553. Unlicensed AFC providers must meet the qualifications described in **Exhibit E.** AFC homes serving four or more participants must be licensed by HHSC under 26 Tex. Admin. Code ch. 553.
Home Delivered Meals	The Provider must comply with requirements for providing home delivered meal services in accordance with 40 Tex. Admin. Code ch. 55.
Minor Home Modifications	There are no licensure or certification requirements.
Adaptive Aids and Medical Equipment/Supplies	There are no licensure or certification requirements.

Provider Responsibilities

Primary Care Provider - Role of a Primary Care Provider (Medical Home)

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

Primary Care Providers (PCPs) may include the following specialties:

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

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

Role of CHIP Perinatal Provider (for CHIP Perinatal only)

CHIP Perinatal Providers provide pregnancy services, since benefits are limited to prenatal care. CHIP Perinatal Members will have a perinatal care Provider. Perinatal care Providers include:

- Family Practitioners
- Obstetrician/Gynecologists

- Internists
- Advanced Nurse Practitioners (ANP)
- Certified Nurse Midwives (CNM)
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

Role of Service Coordinator

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

- Identifying a member's needs through an assessment.
- Documenting how to meet the member's needs in a care plan.
- Arranging for delivery of the needed services.
- 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.
- A service coordinator works as a team with the member and the primary care provider to arrange all the services the member needs to receive, including services from specialists and behavioral health providers (if needed). A service coordinator helps make sure all of the member's different health care needs are met

Long-Term Services and Supports Provider Responsibilities

Long-Term Services and Supports Provider Responsibilities include:

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1. Responsibility to contact Community Health Choice to verify Member eligibility or authorizations for service
2. Continuity of Care
3. Medicaid/Medicare coordination
4. Coordination of benefits for Dual Eligibles as applicable
5. Notification to MCO of change in Member's physical condition or eligibility
6. Community First Choice services
7. Employment Assistance Responsibilities
   a. Providers must develop and update quarterly a plan for delivering employment assistance services.
8. Supported Employment Responsibilities
   a. Providers must develop and update quarterly a plan for delivering supported employment services.
9. The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Community First Choice:

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.

- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Primary Care Provider (Medical Home) Responsibilities

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

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

Providers serving in the role of PCP are responsible for:

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

Preventive Health Services

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

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

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

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

Additional Community Health Choice PCP Responsibilities

- Contact Community Health Choice to verify Member eligibility prior to providing covered services
- Maintain confidentiality of Personal Health Information (PHI) for Community Health Choice Members and adhere to all HIPAA requirements.
- Provide telephonic access to Community Health Choice Members during normal business hours and provide for coverage of after-hours medical emergencies
- Provide or arrange for routine medically necessary care within two weeks of a request and for urgent care within 24 hours of the request
- Maintain an open panel for Community Health Choice Membership that conforms to HHSC guidelines
- Maintain staff membership and admission privileges in good standing with at least one hospital contracted with Community Health Choice, unless otherwise approved
- Be aware of culturally sensitive issues with Members
- Ensure written materials given to Members are on a 4th- to 6th-grade reading level
- Provide care to eligible children who are receiving service from or have been placed in the conservatorship of Texas Department of Family and Protective Services (DFPS)
- Agree not to refer or direct patients to hospital emergency rooms for non-emergent medical services at any time
- Assist in educating and instructing Community Health Choice Members about the proper utilization of Provider office visits in lieu of the emergency room
- Maintain both general liability and professional liability insurance of a type, and in the amounts acceptable, to HHSC as specified in the HHSC Uniform Managed Care Contract
- Meet all Community Health Choice credentialing and re-credentialing requirements
- Permit release of confidential information only under circumstances described in the HHSC Medicaid Provider Procedures Manual
- Submit and maintain claims using the assigned Community Health Choice Provider and referral authorization number
- Maintain all medical records relating to Community Health Choice Members for a period of at least ten

years from the initial date of service
- Comply with federal regulations that protect against discrimination and the federal Americans with Disabilities Act (ADA)
- Maintain any and all licenses in the State of Texas as required by the laws governing his/her profession or business
- Notify Community Health Choice of any policy or procedure that creates a barrier to care

Specialist as Primary Care Provider

Members with disabilities, special health care needs, and chronic or complex conditions may make a request to Community Health Choice to use a specialist as the Member's PCP. The specialist must either be: 1) a currently credentialed and contracted provider in Community Health Choice's network; or 2) be eligible for credentialing according to Community Health Choice's Credentialing Policies and Procedures. The specialist must agree to perform all PCP duties required in the contract including meeting the after hour coverage requirements and other access standards. PCP duties must be within the scope of the specialist's license. The member must have a demonstrated medical need to utilize a specialist as the PCP. Medical need will be determined on a case-by-case basis and will include but not be limited to the following areas:

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

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

The Member must sign a statement indicating consent for the specialist to serve as a Primary Care Physician. The Medical Director of Community will approve or deny the request for special consideration as previously outlined in this section and provide written notification of the decision to the enrollee, not later than thirty (30) days after receiving the request. If the request is denied, Community will provide written notification to the member including the reason(s) for the denial along with information on how to appeal the decision through the complaint and appeals process.

Please confirm Member eligibility by calling Community Health Choice Member Services at 713.295.2295 or 1.888.760.2600 or access eligibility information on our website at CommunityHealthChoice.org. A copy of the PCP referral should be placed in the Member's medical record.
Please confirm the specialist's network status by calling Community Health Choice Provider Services at 713.295.2295.

Specialist Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Community Health Choice Members who have been referred by their PCP for specified consultation, diagnosis and/or treatment. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the PCP.

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

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

Referrals to a specialist cover the time and treatment specified.

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

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

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

Electronic Visit Verification (EVV)

GENERAL INFORMATION ABOUT EVV

1. What is EVV?

EVV is a computer-based system that electronically documents and verifies service delivery information, such as date, time, services type, and location for certain Medicaid service visits. The EVV System captures the following data elements:

- Type of service provided;
- Name of the recipient to whom the service is provided;
- Date and times provider began and ended the service delivery visit;
- The location, including the address at which the service was provided;
- The geolocation for clock in and clock out visits using the mobile application method;
- Name of the Service Provider who provided the service; and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Chapter 532, Subchapter F, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021, and the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs and Services Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Tables on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

4. Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 26, Part 1, Chapter 264, Subchapter A, § 264.103(32), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

5. Do Providers and FMSAs have a choice of EVV Systems?

Yes. A Provider or FMSA must select one of the following two types of EVV Systems:

- State provided EVV system. A state provided EVV system is an EVV System developed and operated by a vendor that contracts with HHSC or HHSC's designated contractor.

Additional information is available on the TMHP EVV Vendors webpage.

- EVV proprietary system. An EVV proprietary system is an approved EVV System that a Provider or FMSA may choose to use instead of a state provided EVV system. An EVV proprietary system:
    - Is purchased or developed by a Provider or an FMSA.
    - Is used to exchange data with the EVV Aggregator;
    - Complies with HHSC EVV Business Rules for EVV Proprietary Systems; and
    - Complies with the requirements of Texas Government Code Chapter 532, Subchapter F.

  Additional information is available on the TMHP EVV Proprietary System webpage.

6. Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select a state provided EVV system, a Provider or FMSA, must complete, sign, date and submit the EVV Provider Onboarding Form directly to the state provided EVV system vendor.

  Additional information is available on the TMHP EVV Proprietary System website to access approved EVV proprietary system vendors and contact information.

- To use an EVV proprietary system, a Provider or FMSA, must visit the TMHP Proprietary System website to review the EVV PSO Onboarding process and review EVV Policy Handbook, Section 5030, EVV Proprietary System Onboarding Process.

  Additional information is available on the TMHP EVV Proprietary System webpage.

8. What requirements must a Provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The Provider or FMSA must complete, sign, date, and submit the EVV Provider Onboarding Form directly to the selected state provided EVV system vendor.

  EVV system vendor information is available on the TMHP EVV Vendors webpage.

  Provider's or FMSA's signature authority must sign and submit an electronic EVV Proprietary System Request Form and complete the EVV PSO Onboarding Process to receive written approval to use an EVV proprietary system.

Additional information/instructions to submit the EVV Proprietary System Request Form and for EVV PSO Onboarding Process is available on the TMHP EVV Proprietary System webpage.

- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either a state provided EVV system vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer to Question #18; and
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data;
        - Enter or verify member service authorizations;
        - Setup member schedules (if required);
        - Create the service provider or CDS Employer profiles and credentials; and
        - For FMSAs only, create unique CDS Employer profiles and credentials depending on the option selected on Form 1722, Employer's Selection for Electronic Visit Verification Responsibilities.

9. Does a Provider or FMSA pay to use the selected EVV System?

If a Provider or FMSA selects a state provided EVV system, the Provider or FMSA uses the system free of charge.

If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from a state provided EVV system to an EVV proprietary system;
- Transfer from an EVV proprietary system to a state provided EVV system; or
- Transfer from one EVV proprietary system to another EVV proprietary system.

11. What is the process to change from one EVV System to another EVV System?

- How to transfer to the state provided EVV System:
    - Proprietary system operators (PSOs) who want to transfer to the state provided EVV system must request a transfer with TMHP at least 120 days before the desired system transfer effective date. The transfer may occur before the 120 days if a PSO and the state provided EVV system vendor agree on an earlier date.
        - The 120-day transfer time frame allows for:
            - Training on the state provided EVV system
            - Transfer of data if requested by the PSO.
            - Completion of all tasks necessary to use the state provided EVV system.

FMSAs approved as a PSO must tell CDS employers at least 60 days in advance of the planned system transfer effective date to allow time to retrain CDS employers and their CDS employees on the state provided EVV system.

- The PSO must:
  - Complete a Termination Form with their current EVV proprietary system 120 days before the desired system transfer effective date.
  - Complete an EVV Provider Onboarding Form with the state provided EVV system vendor 120 days before the desired Go-Live date.
    - Select transfer on the form.
    - Submit to the state provided EVV system vendor.

Transfer process:

- The state provided EVV system vendor will contact the signature authority or the EVV System Administrator within five business days of receipt to confirm the request to transfer and acknowledge receipt.
- The PSO will contact the EVV proprietary system vendor to discuss the transfer request and agree on a date to transfer data to the state provided EVV system.
- The EVV proprietary system vendor will communicate the date to transfer data to the state provided EVV system vendor and TMHP.
- The state provided EVV system vendor must import data within five business days of receipt on behalf of the PSO.
- The state provided EVV system vendor will tell the PSO and TMHP within five business days of completing the data transfer.
- The state provided EVV system vendor will provide further onboarding and EVV system training instructions.

PSOs transferring to the state provided EVV system:

- Must follow EVV Policy Handbook, section 4100, EVV System Selection and section 4700, EVV System Transfer.
- Must make sure all staff, service providers and CDS employers complete EVV system training before using the state provided EVV system.
  - CDS employers must make sure their employees complete training before using the state provided EVV system.
  - Will not receive a grace period for complying with EVV Policy.
  - May have EVV claims denied or recouped.

- How to transfer to an EVV Proprietary System
  - Providers (including program providers approved as proprietary system operators (PSOs)), or FMSAs (including FMSAs approved as proprietary system operators (PSOs)) who want to transfer to an EVV proprietary system from the state provided EVV system or another EVV proprietary system, must:
    - Submit an electronic EVV Proprietary System Request Form through the EVV Portal.

- Submit a Termination Form to the state provided EVV system vendor or current EVV proprietary system vendor within seven days of TMHP accepting the program provider or FMSA into an Operational Readiness Review (ORR) session.
- Accept assignment to an ORR and complete all steps in EVV Policy Handbook, section 5000, EVV Proprietary System.

Transferring from the state provided EVV system to an EVV proprietary system or from one EVV proprietary system to another can only occur after:

- Successful completion of the PSO onboarding process.
- TMHP provides written approval of the EVV proprietary system.
- TMHP and the PSO agree on a system transfer effective date.

Providers or FMSAs who transfer from the state provided EVV system to an EVV proprietary system or PSOs who transfer from one EVV proprietary system to another:

- Must make sure all staff, service providers and CDS employers complete EVV system training before using the new EVV proprietary system.
    - CDS employers must make sure their employees complete EVV system training before using the new EVV proprietary system.
- Will not receive a grace period for complying with EVV Policy.
- May have EVV claims denied or recouped.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendor provides an accessible system, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the state provided EVV system, the state provided EVV system vendor will determine if an accommodation can be provided. However, state provided EVV system vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the EVV proprietary system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:

- Name of the MCO;
- Name of the Provider or FMSA;
- Provider or FMSA Tax Identification Number;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Member Medicaid ID;
- Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
- Authorization start date; and
- Authorization end date.

- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System.
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use an HHSC-approved clock in and clock out method to begin and end service delivery when providing EVV services to a member in the home or in the community.

HHSC has approved three clock in and clock out methods:.

- Mobile method
- Home phone landline
- Alternative device

A proprietary system operator (PSO) must offer one or more of the three HHSC-approved clock in and clock out methods listed above. If the PSO only offers one clock in and clock out method, it must be the mobile method.

The state provided EVV system vendor must provide access to all approved clock in and clock out methods at no cost to the member, program provider, FMSA, CDS employer, service provider, HHSC, MCO or TMHP, except for alternative devices as described in the EVV Policy Handbook, section 7040, Alternative Device.

Mobile Method:

- A Service Provider or CDS Employee must use one of the following mobile devices to clock in and clock out:
  - Their personal smartphone or tablet;
  - A smartphone or tablet issued by the Provider or FMSA;

A Service Provider must **not** use a member's smartphone or tablet to clock in and clock out.

- A CDS Employee must use one of the following mobile devices to clock in and clock out:
    - Their personal smartphone or tablet;
    - A smartphone or tablet issued by the FMSA;
    - A smart phone or tablet owned by the CDS employer, if permission is granted; or
    - A smart phone or tablet purchased by the CDS employer for the CDS employee's use.
- If the mobile method is offered as a clock in and clock out method, the state provided EVV system vendor or EVV proprietary system vendor will supply a downloadable application for use on a smartphone or device with internet connectivity.
- The EVV allowed geo-perimeter is within 250-1320 feet of the member's home. The state provided EVV system vendor or EVV proprietary system vendor may select a geo-perimeter that meets their business needs if that geo-perimeter falls within the EVV allowed distance.
    - If a service provider or CDS employee clocks in or clocks out within the geo-perimeter selected by the state provided EVV system vendor or PSO, the default service delivery location is the member home. The member home is the physical address where a member who receives EVV services resides. The service provider or CDS employee can select a different service delivery location if necessary.
    - If the service provider or CDS employee clocks in or clocks out beyond the geo-perimeter selected by the state provided EVV system vendor or the PSO, the service provider or CDS employee must select a service delivery location.
        - Service Delivery Location options include:
            - Member Home
            - Family Home
            - Neighbor's Home
            - Community
- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

Home Phone Landline:

- A Service Provider or CDS Employee may use the Member's home phone landline or a landline in another location where the Member frequently receives services, if the Member agrees, to clock in and clock out of the EVV System. A voice over internet protocol (VOIP) phone, is also allowable if it is a dedicated phone that requires fixed equipment at a specific address.
    - To use a home phone landline, a Service Provider or CDS Employee must call the state provided EVV system vendor or PSO's toll-free number to clock in and clock out.
    - If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
    - The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

Alternative device

- An alternative device is an approved electronic device that allows a Service Provider or CDS Employee to clock in and clock out of the EVV system from the Member's home.
    - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
    - The alternative device codes from the state provided EVV system vendor are active for only seven days after the date of service and must be entered into the state provided EVV system before the code expires.
    - The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
    - An alternative device must always remain in the Member's home even during an evacuation.
    - Per EVV Policy Handbook, section 7040, Alternative Device, HHSC limits the number of free alternative devices each provider and FMSA may order from the state provided EVV system vendor for assignment to the member.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider or CDS Employee does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider, FMSA, or CDS Employer must manually enter the visit in the EVV System using visit maintenance.
- If a Service Provider or CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider, FMSA, or CDS Employer must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- •Either the FMSA or the CDS employer will perform visit maintenance to correct the CDS Employee's visit transaction in accordance with the CDS Employer's selection on Form 1722.

- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.

- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

16. Is there a timeframe in which Providers, FMSAs, CDS Employers, and Proprietary System Operators (PSO) must perform Visit Maintenance?

In general, a Provider, FMSA, CDS Employer, or PSO must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: HHSC may extend the visit maintenance timeframe as needed.

17. Are Providers, FMSAs, CDS Employers, and PSOs required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Providers, FMSAs CDS Employers, or PSOs must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the overall issue for the need to complete Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) provides more detail about why the Provider, FMSA, CDS Employer, or PSO completed Visit Maintenance.
- Free text is additional information the provider, FMSA CDS Employer or PSO must, if applicable, enter to further describe the need for Visit Maintenance.

Reason Codes information is located on the home page of the HHSC EVV website at Electronic Visit Verification | Texas Health and Human Services.

EVV TRAINING

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the state provided EVV system vendor or EVV PSO
  - EVV Portal training provided by TMHP
  - EVV Policy training provided by HHSC or the MCO

- CDS Employers must complete training based on delegation of Visit Maintenance on *Form 1722*, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System:
    - EVV System training provided by the state provided EVV system vendor or EVV PSO
    - Clock in and clock out methods

        - EVV Policy training provided by HHSC, the MCO or FMSA

    - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
        - EVV System training provided by state provided EVV system vendor or EVV PSO
        - EVV Policy training provided by HHSC, the MCO or FMSA

    - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
        - Overview of EVV Systems training provided by stete provided EVV vendor or EVV PSO
        - EVV policy training provided by HHSC, the MCO or FMSA.

- Providers must train Service Providers and CDS Employers must train CDS Employees on the EVV clock in and clock out methods.

Community's EVV training requirements and information is available on the Community EVV website at https://provider.communityhealthchoice.org/electronic-visit-verification/.

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
    - EVV Usage Review – meet the minimum EVV Usage Score.
    - EVV Landline Phone Verification Review – ensure valid phone type is used; and
    - EVV Alternative Device Usage Reviews – ensure percent of EVV visit transactions recorded with an alternative device is within the allowable percentage per the alternative device reduction schedule.

Information about Community's EVV Compliance Reviews is available on the Community EVV website at https://provider.communityhealthchoice.org/electronic-visit-verification/.

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's
submission requirements.

EVV Claims and billing information is located on both the Community EVV website at https://provider.communityhealthchoice.org/electronic-visit-verification/ and the HHSC EVV website in the *Electronic Visit Verification Policy Handbook, Section 13000 EVV Claims* including all sub- sections, at 13000 EVV Claims | Texas Health and Human Services.

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or
deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or

more accepted EVV visit transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims match process is complete.

The following data elements from the claim line item and EVV visit transaction must match:

- Medicaid ID
- Date of service
- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Healthcare Common Procedure Coding System (HCPCS) code
- HCPCS modifiers
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the *EVV Service Bill Codes Tables* for the specific services that bypass the units matching process.

Based on the result of the EVV claims match process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.

- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.The EVV Aggregator will still perform the claims match process between the EVV claim line item and the EVV visit transaction to record the actual claims match results. Providers and FMSAs can view the actual claim match results in the EVV Portal to find out if the claim would have matched without the bypass.
- The MCO may recoup the EVV claim, if the Provider, FMSA, or PSO does not follow the MCO's instructions related to claims match result code of EVV07 or EVV08.

25. How can a Provider and FMSA see the results of the EVV claims matching process?

Providers, FMSAs, and PSOs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.
Detailed information including job aids is located on the TMHP EVV Training webpage at EVV Training | TMHP.

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss ofprogram eligibility; or the Provider's or FMSA's failure to obtain prior authorization for a service.

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 713.295.2294 or 1.888.760.2600 prior to each visit.

Second Opinions

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

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

Appointment Availability Standards

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

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

Emergent/Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in one or all of the following:

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

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

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

Primary Care Provider 24-Hour Availability

PCPs are required to provide 24-hour availability, seven days a week for Community Health Choice Members. Arrangements for coverage while off-duty or on vacation are to be made with other participating Providers. Community Health Choice should be notified of the Provider's coverage prior to a leave of absence.
Community Health Choice's contracts state that PCPs must "be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, seven days a week." Additionally, the contracts state that PCPs must "maintain one of the following to receive calls from Members after normal business hours:"

Acceptable after-hours coverage

1. The office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;

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

Unacceptable after-hours coverage

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

Standards for Medical Records

Accessibility and Availability of Medical Records

Community Health Choice includes provisions in contracts with subcontractors for appropriate access to the medical records of its Members for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, state agencies or any agents thereof. All medical records must be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of patient records. Provider must retain medical records for a period of ten years following termination of the Provider's contract with Community Health Choice or longer as mandated by any applicable State or federal law.

Record Keeping

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

Medical Record Standards

Community Health Choice sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of HIPAA and other federal and state laws. Medical records shall, at a minimum, include requirements for:

- Patient Identification Information: Each page or electronic file in the record contains the patient's name or patient ID number.
- Personal/Biographical Data: Include age, sex, address, employer, home and work telephone numbers, and marital status
- Complete: All entries are dated and author identified.
- Legible: The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- Allergies: Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies — NKA) is noted in an easily recognizable location.
- Past medical history (for patients seen three or more times): Past medical history is easily identified, including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
- Immunizations: For pediatric records, there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Diagnostic information: Includes medication information/instruction to Member

- Identification of current problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical record.
- Education: Member is provided basic teaching/instructions regarding physical and/or behavioral health condition.
- Smoking/alcohol/substance abuse: Notation concerning cigarettes and alcohol use and substance abuse is present— abbreviations and symbols may be appropriate.
- Consultations/Referrals/Specialist Reports: Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- All emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled
- Hospital discharge summaries are included as part of the medical record for (1) all hospital admissions that occur while the patient is enrolled with the contractor and (2) prior admissions, as necessary.
- Discharge summaries from prior admissions, as necessary, pertaining to admissions that may have occurred prior to Member being enrolled with Community Health Choice and are pertinent to the Member's current medical condition.
- For medical records of adults, the medical record documents whether the individual has executed an advance directive—an advance directive is a written instruction, such as a living will or durable power of attorney, for health care relating to the provision of health care when the individual is incapacitated.
- Documentation: Documentation of evidence and results of medical, preventive, and behavioral health screening
- Documentation of all treatment provided and results of such treatment
- Documentation of the team members involved in the multidisciplinary team of a Member needing specialty care
- Documentation in both the physical and behavioral health records of integration of clinical care.
- Documentation to include:
  - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health Providers when problems are indicated
  - Screening and referral by behavioral health Providers to PCPs when appropriate
  - Receipt of behavioral health referrals from physical medicine Providers and the disposition/outcome of those referrals
  - At least quarterly (or more often if clinically indicated) summary of status/progress from the behavioral health Provider to the PCP

- Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder
- A written release of information that will permit specific information sharing between Providers.

- In addition, each Provider's office must have:
  - A written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use
  - Written procedures for release of information and obtaining consent for treatment

Patient Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and physical examination: Appropriate subjective and objective information is obtained for the presenting complaints.
- For Members receiving behavioral health treatment, documentation to include "at-risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history)
- Admission or initial assessment includes current support systems or lack of support systems
- For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/ symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased or unchanged during treatment period.
- Plan of treatment: Includes activities/therapies and goals to be carried out
- Therapies and other prescribed regimens: For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions when appropriate.
- Follow-up: Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN. Unresolved problems from previous visits are addressed in subsequent visits
- Diagnostic tests
- Referrals and results
- All other aspects of patient care, including ancillary services

Record Review Process

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

Coordination with Department of Family and Protective Services (DFPS)

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

- Providing medical records to DFPS
- Recognition of abuse and neglect and appropriate referrals to DFPS

Provider Marketing Guidelines

1. Providers are permitted to inform their patients about the CHIP and Medicaid Managed Care Programs in which they participate.
2. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, Providers must not recommend one MCO over another MCO, offer patients Incentives to select one MCO over another MCO or assist the patient in deciding to select a specific MCO.
3. At the patients' request, Providers may give patients the information necessary to contact a particular MCO or refer the Member to an MCO Member Orientation.
4. Providers must distribute or display health-related Materials for all contracted MCOs or choose not to distribute or display for any contracted MCO:
   a. Health-related posters cannot be larger than 16" x 24".
   b. Health-related Materials may have the MCO's name, logo and contact information.
   c. Providers are not required to distribute or display all Health-related Materials provided by each MCO with whom they contract. A Provider can choose which items to distribute or display as long as the Provider distributes or displays one or more items from each contracted MCO that distributes items to the Provider and the Provider does not give the appearance of supporting one MCO over another.
5. Providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the Provider participates with a particular MCO cannot be larger than 5" x 7" and cannot indicate anything more than "MCO is accepted or welcomed here."
6. Providers may choose whether to display items such as children's books, coloring books, and pencils provided by each contracted MCO. Providers can choose which items to display as long as they display one or more from each contracted MCO. Items may only be displayed in Common Areas.
7. Providers may distribute Applications to families of uninsured children and assist with completing the Application.
8. Providers may direct patients to enroll in the CHIP and Medicaid Managed Care Programs by calling the HHSC Administrative Services Contractor (ASC) at 1.800.964.2777.
9. Bargains, premiums or other considerations on prescriptions may not be advertised in any manner in order to influence a Member's choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the Program.

Options for Member Non-Compliance

Contact Provider Services at 713.295.2295 in the event that a Member is non-compliant, becomes abusive to you or your staff and/or continues to demand services that, in your professional judgment, are not medically necessary.

The problem will be researched and resolved. A PCP must request (in writing to Community Health Choice) that a Member be transferred to another primary care physician for the following reasons:

- Member is disruptive, unruly, threatening or uncooperative to the extent that the Member's behavior seriously impairs the Provider's ability to provide services to the Member, provided the behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the Provider to treat the underlying medical condition.
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary and the Member has received full informed consent regarding the prescribed treatment course.

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

Remember, physicians are not allowed to withhold or discriminate in any way in the treatment of a Member or to transfer a Member from his/her practice because of the health condition of a Member or the amount of services provided. A PCP cannot transfer a Member to another PCP without the prior written authorization of the Community Health Choice Medical Director. Community Health Choice requests that the physician continue care until Community Health Choice can successfully transfer the Member to a new PCP. PCPs shall not refuse to accept a Member as a patient on the basis of health status, previous use of services or the medical condition of the Member.

The Member Education Request Form and Request for Member Reassignment Form can be found at CommunityHealthChoice.org.

Dispute Resolution for Providers

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

Disputes Involving Administrative Matters

Disputes involving administrative matters are those which arise from non-clinical or administrative issues from contracted Providers. Additional information is located in the "Complaints and Appeals" section for each program in this manual.

Disputes Concerning Professional Competence or Conducts

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

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

- *Investigation*

  A routine investigation may be initiated by any Senior Manager of Community Health Choice, the Medical Affairs Department, the CEO, the Medical Director or the Medical Care Management Committee (MCMC). The investigation will be conducted by, or under the direction of, the Medical Director. The investigative process is not an appeal hearing.

  An investigation may involve consultation with the Provider, the individual or group making the request or other individuals who may have knowledge of the events. The Medical Director may also consult with Providers of same or similar specialties of the disputing Provider within the community, including medical schools, Special Investigative Unit (SIU) or same or similar specialists from an independent review company.

- *Results of Investigation*

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

- *Appeal Hearing (Appeals)*

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

  Level 2: The second-level appeal panel will consist of at least three contracted Providers who are not otherwise involved in the day-to-day operations of Community Health Choice, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier actions. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report to the Medical Director and CEO for implementation of their recommendation. The Provider will be notified of the second appeal panel's findings, which are considered final.

- *Reapplication Subsequent to Adverse Action*

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

Important Notes

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

- Automatic suspension from the Member panel shall occur whenever:
  - A practitioner's state license or DEA number is revoked, suspended, restricted or placed under probation;
  - A practitioner fails to satisfy an interview requirement;
  - A practitioner fails to maintain malpractice insurance; and

- A practitioner's medical records are not completed in a timely manner.

- State License Revocation – Whenever a practitioner's license to practice in this state is revoked, his or her panel appointment and practice privileges are immediately and automatically revoked.
- Restriction – Whenever a practitioner's license is partially limited or restricted, his or her practice privileges are similarly limited or restricted.
- Suspension/Probation – Whenever a practitioner's license is suspended or placed on probation, his or her practice privileges are automatically suspended, effective upon, and for at least the term of, the suspension.
- Drug Enforcement – Whenever a practitioner's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a licensing authority (DEA/CDS), his or her privileges to prescribe such substances to MCO enrollees will also be revoked, restricted, suspended, or placed on probation automatically and to the same degree. This will be effective upon, and for at least the term of, the imposed restriction.
- Professional Liability Insurance – A practitioner who fails to maintain a minimum amount of professional liability insurance will have his or her practice privileges immediately suspended.
- Medical Records Preparation and Completion – The Member panel policies, rules and regulations outline the requirements for medical record preparation and completion.
- Timely Completion – A practitioner's failure to prepare and/or complete medical records within the time period stated in the policy may result in the limitation or automatic suspension of some or all of the practitioner's privileges.
- Loss of Hospital Privileges – A practitioner who loses his or her hospital privileges due to incomplete medical records will automatically lose his or her MCO practice privileges for at least the term imposed by the hospital.
- Re-application Subsequent to Corrective Action – A practitioner who has been denied practice privileges or who has been removed from the Member panel during the appointment year may not reapply for panel appointment or practice privileges for a period of one year (12 months), unless specified otherwise in the terms of the corrective action.

Provider Portal

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

Forms for Providers

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

Network Referrals

Network Limitations

Community Health Choice has an open network. Providers are able to refer Members to the Community Health Choice website or the current Community Health Choice Provider Directory. Members may go to any in-network Provider. While we have an open network at this time, we encourage Members to choose a PCP and schedule appointments as needed.

Referral to Ophthalmologist or Optometrist

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

Network Pharmacy

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

Members with Special Health Care Needs

Members with special needs have direct access to a specialist as appropriate for Member's conditions and identified needs. Community Health Choice does not require prior authorization for in- network specialists. Community encourages that all health care services should be coordinated through the Member's PCP for referrals to a specialist in-network provider, when necessary and available. Requests for out-of-network specialty providers require prior authorization.

Referral to Specialists and Health-Related Services

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

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

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

Specialist Scheduling Service

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

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

inquiries

Website: https://ProviderPortal.CommunityHealthChoice.org/Providers/Secure/Referrals/Specialist.aspx?product=Medicaid

Phone: 713.295.2450 or 1.888.760.2600

Fax specialist consultant appointment form to 713.295.7050.

Referral to Network Facilities and Contractors

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

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

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

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

Continuity of Care

Pregnant Woman Information

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

Member Moves Out of Service Area

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

Members should notify Community Health Choice Member Services at 713.295.2294 along with 2-1-1 or 1.877.541.7905.

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

Pre-Existing Conditions

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

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

Special Access Requirements

Interpreter/Translation Services

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

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

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

Providers can communicate with some hearing-impaired Members in writing during office visits. Community Health Choice can help Providers communicate with the hearing impaired by telephone with a translation device for the deaf. Call Community Health Choice Member Services TDD/TTY telephone line at 1.800.735.2989 for assistance in any language. Some hearing-impaired Members, especially those who became deaf pre-lingual, may not be able to communicate in writing, but can communicate in sign language. If a Community Health Choice Member needs a face-to-face interpreter in your office, call Community Health Choice Member Services at least three business days in advance of the Member's appointment.

MCO/Provider Coordination

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

- Maternal and Child Health
- Children with Special Healthcare Needs (CSHCN)

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

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

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

They must:

- Participate in hospital discharge planning
- Participate in pre-admissions hospital planning for non-emergency hospitalizations
- Develop specialty care and support service recommendations to be incorporated into the PCP's plan of care
- Provide information to the Member and the Member's family concerning the specialty care recommendations

Please contact Community Health Choice Member Services to assist in coordinating any services that our Members may need such as:

- Transportation to a medically necessary appointment
- Translation services

Reading/Grade Level Consideration

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

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

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

Above all else, be sensitive to the embarrassment the Member may feel about limited literacy.

Community Health Choice Member Services can assist with interpreters.

Cultural Sensitivity

Cultural sensitivity refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each.
Community Health Choice's interpretive services will help you provide care in a culturally competent manner.

Members requiring behavioral healthcare services should preferably be referred to treatment Providers who speak the Member's language and have an understanding of related cultural issues. In the event that a Member requires a behavioral health Provider who speaks another language or has specific expertise with a specific culture, they may contact Member Services at 1.877.343.3108 to receive appropriate referrals.

Non-Emergency Medical Transportation (NEMT) – STAR only

Members can receive non-emergent medical transportation services through Access2Care.

How to get a ride?

Members can schedule a ride by calling Access2Care toll-free at 844.572.8194 or via the Access2Care (A2C) Member app. The app is available via the app store.

The Member should have the following information when calling to schedule transportation:

- Name of the doctor
- Address
- Telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair-accessible van)
- Member ID Number

Members should request NEMT services as early as possible and at least 48 hours before the Member needs the NEMT service. In certain circumstances, a Member may request the NEMT service with less than 48 hours' notice. These circumstances include being picked up after discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency, but is severe or painful enough to require treatment within 24 hours.

The Member must notify Access2Care prior to the approved and scheduled trip if medical appointment is cancelled.

Transportation Value-Added Services

Members will be permitted to have additional riders as long as they fit in the designated vehicle. The Texas law requiring car and booster seats applies.

Emergency Services

Emergency Room Services

Emergency room Providers are authorized by Community Health Choice to provide medically necessary and appropriate treatment for any Community Health Choice Member. If a Community Health Choice Member needs to be admitted, the hospital must notify the Community Health Choice Utilization Management Department within 24 hours of the admission or the next business day by either calling 713.295.2295 or 1.888.760.2600, by faxing the encounter record to 713.295.2284 or on our website at CommunityHealthChoice.org. The PCP should also be notified by the hospital about the admission within 24 hours or the next business day. Whenever a Community Health Choice Member presents to an emergency room with a non-emergent condition, the Member must be assessed, and their PCP must be contacted (the name of the PCP is located on the Member ID card) for appropriate treatment or education.

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

- Document attempts to contact the PCP
- Treat the Member

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

Emergency Prescription Supply

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

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

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

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "Prior Authorization type Code" (Field 461-EU) = '8'
- "Prior Authorization Number Submitted" (Field 462-EV) = '801'
- "Days' Supply" in the claim segment of the billing transaction (Field 405-D5) = '3'
- "Quantity Dispensed" should equal the amount for a three-day supply (Field 442-E7)

Call Navitus Customer Care toll free at 1.877.908.6023 for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation

The ambulance transport is an emergency service when the condition of the client is life threatening and requires use of special equipment, life-support systems, and close monitoring by trained attendants while in route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could result in serious impairment, dysfunction or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

Non-Emergency Transportation

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

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

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

Behavioral Health

Behavioral health services are covered services for the treatment of mental health and emotional disorders, as well as substance abuse disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications and/or ICD-10 classification systems. Those services include treatment at inpatient, outpatient, and divisionary levels of care.

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

Medically necessary behavioral health services are:

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

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

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

Behavioral Health Appointment Accessibility Standards

Emergent/Life Threatening	Immediate
Urgent	Within 24 hours
Routine Primary Care	Within 14 days of the request
Initial Outpatient Behavioral Health	Within 14 days

Specialty Routine	Within 21 days
Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission	Within 7 days from the date of discharge

Primary Care Provider Requirements for Behavioral Health

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

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

The Provider is responsible for maintaining treatment records and obtaining a written medical record release from the Member or a parent/legal guardian of the Member before records can be released.

Self-Referral

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

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

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

- Calling Provider Services at 713.295.2295 or
- Faxing referral information to our dedicated behavioral health faxes at 713.576.0932 for inpatient or 713.576.0931 for outpatient.

Behavioral Health Services

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

- Behavioral health assessment and referral services
- Individual, family, and group counseling
- Acute inpatient hospitalization
- Short-term residential
- Partial hospitalization for mental health conditions
- Intensive outpatient programs

- Medication evaluation and monitoring
- Referral for other community services
- Case management
- Attention Deficit Hyperactivity Disorder (ADHD) services
- Targeted Case Management
- Mental Health Rehabilitative Services

Mental Health Rehabilitative Services and Mental Health Targeted Case Management

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

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

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

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

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

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

- **Medication training and support**: curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- **Psychosocial rehabilitative services**: social, educational, vocational, behavioral or

cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development

- **Skills training and development**: skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- **Crisis intervention**: intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting
- **Day program for acute needs**: short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

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

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

MHR and TCM services, including any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. Community Health Choice will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but we are not responsible for providing any services listed in the RRUMG that are not covered services. Community Health Choice must accept the level of care generated by the CANS/ANSA and may not prior authorize MHR /TCM services based on medical necessity. Providers must review a Member's plan of care for MHR services in accordance with the RRUMG to determine whether a change in the Member's condition or needs warrants a reassessment or change in service.

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

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

ability to provide, either directly or through subcontract, the full array of RRUMG services to Members.

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

Coordination between Behavioral Health and Physical Health Services

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

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

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

Medical Records Documentation

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

Consent for Disclosure of Information

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

Court-Ordered Commitments

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

Community Health Choice:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient

or outpatient psychiatric services for Members age 20 and younger or ages 65 and older; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination.

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

Coordination with Local Mental Health Authority (LMHA)

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

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

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

Assessment Instruments for Behavioral Health: PCP Toolkit

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

Conditions included in the toolkit:

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

- Opiates
- PTSD
- Schizophrenia

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

Inpatient Discharge Follow-Up and Missed Appointment Procedures

Community Health Choice Members receiving inpatient psychiatric services must be scheduled for outpatient treatment prior to discharge. They must receive outpatient treatment within seven days from the date of discharge and a follow up appointment within 30 days after hospitalization for mental illness. Behavioral health aftercare services can be provided by psychiatrists, psychologists, licensed therapists or alternative care services as appropriate for the individual Member. Missed appointments should be rescheduled within 24 hours.

Members with behavioral health diagnosis are also monitored for readmission to an inpatient facility. Results of these reports and focused studies are available to Providers upon request.

Physical Health Lab/Ancillary Tests

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

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

Behavioral Health Focus Studies and Utilization Management Reporting Requirements

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

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

Dental Services

Role of Main Dental Home

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

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

How to Help a Member Find Dental Care

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

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

Emergency Dental Services

Medicaid Emergency Dental Services:

Community Health Choice is **responsible** for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

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

CHIP Emergency Dental Services:

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

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

Non-Emergency Dental Services

Medicaid Non-Emergency Dental Services:

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

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

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

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

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

CHIP Non-Emergency Dental Services:

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

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

Pharmacy

Pharmacy benefits for Community Health Choice Members are administered by Navitus Health Solutions, a pharmacy benefit management company. For questions related to pharmacy benefits, including participating pharmacies, formulary, preferred drugs, billing, prescription overrides, prior authorizations, quantity limits, or formulary exceptions, please call Navitus Customer Care toll free at 1.877.908.6023 or visit Navitus.com. The Navitus formulary adheres to the VDP formulary and preferred drug list and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called HHSC's DUR Board and VDP.

Role of Pharmacy

Community Health Choice makes payment for medically necessary prescriptions of covered outpatient drugs to pharmacy Providers contracted with Navitus. Medicaid Members may receive medically necessary prescriptions from the Medicaid enrolled pharmacy of their choice. Navitus contracts with most pharmacies.

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

Pharmacy Provider Responsibilities

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

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

How to Find a List of Covered Drugs

Drugs eligible for reimbursement are listed in the current Texas Medicaid formulary. The formulary is available at Navitus.com/Texas-Medicaid-STAR-CHIP/formulary.aspx.

How to Find a List of Preferred Drugs

Providers can find a list of preferred drugs at www.txvendordrug.com/formulary/prior- authorization/preferred-drugs.

How to Find a List of PA Required Services and Codes

A list of covered drugs is available via the provider portal or at https://txstarchip.navitus.com/pages/formulary.aspx. On the formulary, medications that require prior authorization for coverage are marked with "PA." A response of "PA Not Required" on a returned

request form is not a guarantee of payment. “PA Not Required” does not mean that service is covered.

Process for Requesting Prior Authorization

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

Navitus processes Texas Medicaid pharmacy PAs for Community Health Choice. The formulary, PA criteria, and the length of the PA approval are determined by HHSC. Information regarding the formulary and the specific PA criteria can be found at the Vendor Drug Program website, ePocrates, and SureScripts for ePrescribing.

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

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

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

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

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

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

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

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

Authorizations for Health Services

Prior Authorization

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

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

Services Requiring Authorization

The list of services 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 713.295.2295 for further information if you are unsure of prior authorization requirements. The list of services is subject to change and will be updated as required.

Clinical Practice Guidelines

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

- Disease Management
- Complex Case Management
- Two behavioral health conditions, one of which addresses children and adolescents
- Preventive Health Guidelines for the following:
    - Perinatal care
    - Care for children up to 24 months old
    - Care for children 2 – 19 years old
    - Care for adults 20 – 64 years old
    - Care for adults 65 years and older

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

InterQual

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

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

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

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

Prior Authorization Requests

Community Health Choice accepts Community Health Choice's Preferred Prior Authorization Form as well as the Texas Standard Prior Authorization Form. Submit requests for authorization via the Provider Portal or via fax to 713.295.2283 or 1.844.899.2495. To avoid delays, include supporting documentation and clinical notes to support your request for authorization of services.

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

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

Essential Information

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

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

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

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

Supporting Clinical Documentation

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

Lack of Information

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

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

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

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

Failure to Obtain Prior Authorization or Referral

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

Prior Authorization Determination Timeframes

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

Prospective Review

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

Concurrent Review

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

Retrospective Review

Based on the Retrospective Review Policy for authorizations, if certain conditions are met Community will issue a determination, Community will issue a determination within 30 calendar days from the receipt of request for a retrospective UM determination for a service that Provider has already rendered and for which Provider has not submitted a claim. Fax requests for Retrospective Review with supporting documentation to 713.576.0937.

Peer-to-Peer

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

Authorization for Out-of-Network Services

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

Utilization Management Reporting Requirements

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

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

Care Management

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

PCPs are expected to transmit information to the Community Health Choice Care/Disease Management Department for those Community Health Choice Members who elect to participate in one of Community Health Choice's Care/Disease Management programs. Requested information will vary with each disease; they may include but are not be limited to:

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

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

Care Management/Disease Management and Community Health Choice Providers

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

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

- Education specific to disease via quarterly updates
- Open access to network specialists and assistance with appointments
- Coordination of ancillary services
- Individualized plan of care
- Telephonic case management
- Transportation assistance
- 24-hour Help Line for Members
- Programs are at no cost to the Member and they can elect to withdraw at any time.

Program	Description	Criteria
High-Risk Perinatal	Targeted to moms-to-be who are high risk and can benefit from education and support	• High risk, history of pre-term births, multiple pregnancies or other complications
Asthma	Targeted interventions for adults, adolescents, and children with asthma	• No age limit
Diabetes	Targeted interventions for Members with Type I and Type II Diabetes	• No age limit
Behavioral Health	Targeted interventions for Members with Behavioral healthcare needs and Serious and Persistent Mental Illness (SPMI).	• No age limit • Combination of complex medical and behavioral health conditions • SPMI and evidence of difficulty navigating the challenges of managing their disease state
Chronic Obstructive Pulmonary Disease	Targeted interventions and plans of care for Members with Chronic Obstructive Pulmonary Disease	• No age limit • High risk
Congestive Heart Failure	Targeted interventions and plans of care for Members with Congestive Heart Failure	• No age limit • High risk
Coronary Artery Disease	Targeted interventions and plans of care for Members with Coronary Artery Disease	• No age limit • High risk

Contact our Care Management/Disease Management department at 832.CHC.CARE (832.242.2273) or 1.888.760.2600.

Referrals may be faxed to 713.295.7028 or e-mailed to CMCoordinators@CommunityHealthChoice.org.

For behavioral health, send email to BHCasemanagementreferrals@CommunityHealthChoice.org

Complex Case Management Program

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

PCPs are expected to transmit information to the Community Health Choice Complex Case Management Department for those Community Health Choice Members who elect to participate in one of Community Health Choice's Complex Case Management programs. Requested information will vary with each disease; they may include but are not limited to:

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

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

Complex Case Management and Community Health Choice Providers

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

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

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

Quality Management

Quality Improvement Program

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

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

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

Quality Improvement Health Services Contracting

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

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

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

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

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

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

Quality Improvement Studies

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

Quality Management for STAR+PLUS

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

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

Performance Improvement Projects

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

Quality Improvement Projects

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

- Support the overall quality management strategy approved by clinical leadership
- Result in a positive measurable impact
- Provide improvement on consumer health outcomes or internal work processes
- The three Quality Improvement Projects are as follows:

- Improving 7 and 30-day follow-up appointments after hospitalization for mental illness
- Improve health outcomes for STAR/CHIP Members through Community Health Choice's Asthma Care Management Program
- Improve well-child appointment rates for Community Health Choice (e.g., HEDIS W30, CIS, IMA, and WCC)

Pay for Quality (P4Q) Program

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

Billing and Claims

Claims Filing

Claims must be filed using the current standard CMS 1500 form, https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1500.pdf or CMS 1450 formerly known as UB-04 form, https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing-items/cms-1450 . Claims must be submitted within 95 days from the date of service.

Electronic Code Sets and Standard Transactions

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

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

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.

Community accepts single and batch claim submissions. Professional or Institutional claims can be submitted through Community’s clearinghouse in single claim or batch claim submission files. Provider’s can also submit single Professional claims through Community’s Provider Portal. Community’s Provider Portal [Does/Does Not] accept Institutional claim filing at this time.

Submitting Claims by Mail

Claims may be submitted by mail to the following address:

Community Health ChoiceAttn: Claims
P.O. Box 301404
Houston, TX 77230

Or by certified mail to the following address:

Community Health Choice Attn: CLAIMS

4888 Loop Central Dr. Houston, TX 77081

Refund Lockbox Address:

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

Clean Claims Payment

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

All “clean” claims will be adjudicated within 30 days of receipt. A Provider will be notified in writing, if additional information is needed to process claim. If a “clean” claim is not adjudicated within 30 days of receipt, claim continues to go unadjudicated.

Pharmacy “clean” claims will be adjudicated within 18 days for electronic pharmacy claim submission. Non-electronic pharmacy claims will be adjudicated within 21 days of submission.

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

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 claim, please follow the guidelines below:

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

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

- If your claim is denied because it did not contain critical claims elements that are required for adjudication of clean claims or you did not submit as indicated above, you may submit your corrected electronic or paper claim with the resubmission code 7 in box 22 of the CMS-1500 claim form or in Loop 2300 electronically. You must indicate the original claim number in the Original Reference number field along with the resubmission code. Print "Corrected Claim" if submitting paper claim.
- 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 and 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

To be reimbursed for services rendered to Medicaid managed care clients, Providers must be enrolled in Texas Medicaid. Community Health Choice cannot pay Providers or assign Medicaid Members to Providers for Medicaid services unless they are included on the state master file provided by the Texas Medicaid & Healthcare Partnership (TMHP). State master files are updated weekly.

Federal regulations require state Medicaid agencies to revalidate Provider enrollment information every three to five years. If a Provider's re-enrollment is not complete by the required date, the Provider will not be able to receive payments for Medicaid services. Compliance with the re-enrollment process is solely the responsibility of the Provider. Additional information is available through TMHP.

Community Health Choice reimburses acute care Providers based on the Texas Medicaid Fee Schedule. These rates are set by the State Medicaid Program and are available at TMHP.com. In accordance with the rules of reimbursement of the Texas Medicaid Program, when a Provider is paid under this type of reimbursement methodology, the Provider is paid the lower of its billed charges or the published Medicaid rate. Please refer to your contract with Community Health Choice for specific contractual provisions and reimbursement rates.

Community Health Choice reimburses LTSS providers based on the LTSS Billing Crosswalk and Rate Tables. These rates are set by the State Medicaid Program and are available on the HHSC website.

Community Health Choice pays the lesser of Provider's billed charges or the contracted rate. Claims are adjudicated based on the authorization that was completed. Facilities must bill their claims with the Present of Admission (POA) identifier, or claims will be denied. Please refer to your contract with Community Health Choice for specific contractual provisions and reimbursement rates.

Monthly Capitation Services

Providers contracted under capitated reimbursement methodologies receive payment on a per-Member-per-month (PMPM) basis. Providers receiving capitation are required to submit encounter data to Community Health Choice for services covered under capitation. Refer to your Provider contract or call Community Health Choice Provider Services at 713.295.2295 for more information.

Adjudication of Claims

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

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

(a) healthcare services within 30 days from the date the claim is received by the MCO;

(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 30 days.

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.

Reminder about NCCI Guidelines and Currently Published Procedure Code Limitations

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

medical policy is more restrictive than NCCI medically unlikely edits (MUE) guidance, Texas Medicaid medical policy prevails.

Claims Audits

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

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

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

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

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

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

Overpayments

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

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

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

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

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

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

Provider Preventable Conditions

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

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

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

Pass Through Billing

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

Emergency Services Claims

An emergency is defined as any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a lay person possessing an average knowledge of

health and medicine could reasonably expect that the absence of immediate medical care could result in:

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

No authorization is required for hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition, as well as services by emergency professional/physicians. This includes a medical screening to evaluate care levels and stabilization services needed to admit or release patient.

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

Emergency service claims are required to follow all claims billing procedures. Claims must identify emergency services with service code 450 or place of service 23.

Time Limit for Submission of Claims/Claims Reconsideration

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

Out-of-Network Provider Payments

Community Health Choice will be responsible for out-of-network claims for Members with care in progress with nonparticipating Providers until Member's records, clinical information, and care can be transferred to a network Provider. Payment shall be within the time limits set forth by the state for network Providers. Payment allowable shall be comparable to what Community Health Choice pays network Providers, an amount negotiated between Provider and Community Health Choice, or the standard non-participating rate of 95% of Texas Medicaid.

Community Health Choice will be responsible for payment for out-of-network Providers who provide covered services to Members who move out of the service area through the end of the period for which the state has paid Community Health Choice for that Member's care.

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

Continuity of Care

Pregnant Woman Information

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

Member Moves Out of Service Area

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

Members should notify Community Health Choice Member Services at 713.295.2294 along with 2-1- 1 or 1.877.541.7905.

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

Pre-Existing Conditions

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

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

CLIA

The CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable federal requirements and have a CLIA certificate in order to receive reimbursement from federal programs. Community Health Choice will deny claims for CLIA-waived lab services if the Provider does not have a valid CLIA certification on file with Community Health Choice.

Billing for Maternity Services

Numerous nationally recognized metrics exist for measuring the quality of obstetrical services, i.e., 1) timeliness of prenatal care, 2) preterm birth rates, 3) primary C-section rates, and 4) postpartum care. In most cases, it is relatively easy to measure physician performance for each of these metrics – with the exception of the metric related to postpartum visits.

While the Texas Medicaid Provider Procedures Manual (TMPPM) and existing Community Health Choice (Community) provider agreements allow physicians to bill for the delivery and postpartum visit using a single CPT code (59410, 59515, 59614, or 59622), this practice restricts Community's ability to determine an actual postpartum visit.

Additionally, when more than one Provider is involved in the care of a Member, Community may receive a claim for the single CPT code indicating delivery and postpartum care from one Provider and a separate claim for postpartum visit(s) from a different Provider for the same Member, complicating claims payment.

Community will not accept the following billing codes for maternity services: 59410, 59515, 59614, and 59622. Providers must bill with the appropriate prenatal, delivery, and postpartum visit codes for our STAR, CHIP and CHIP Perinatal Members.

For additional information specific to CPT codes and billing for maternity services, please review the Texas Medicaid Provider Procedures Manual (TMPPM).

Reminder: CHIP Perinatal

CHIP Perinatal (CHIP P) covers prenatal care, labor with delivery, and two postpartum visits within 60 days after delivery or end of pregnancy. Because a mother's CHIP P enrollment ends at the end of the month in which the pregnancy ended, she may still receive those covered postpartum visits after her enrollment period ends. For example, if a CHIP P-enrolled mother delivered her baby on February 15th, her enrollment ends on February 28th. However, she may receive covered postpartum visits until April 15th.
Should you have additional questions, please call the Provider Services line at 713.295.2295 or contact your Provider Engagement Representative.

Community Health Choice Claims Payment

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

1. **Virtual Card Services** - If ECHO does not have a documented choice of payment for you, the default method of payment will be virtual card rather than a paper check. Virtual cards allow your office to process payments as credit card transactions and are generally received 7-10 days earlier than paper checks since there are no print or mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction, your Explanation of Payment (EOP), and an instruction page for

processing. Once you receive the virtual card number, you simply enter the code into your office's credit card terminal to process payment as a regular card transaction. To avoid delays, please process the card or notify Change Healthcare/ECHO Health of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship. **NO ACTION IS NECESSARY to start receiving Virtual Credit Card payments.**

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

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

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

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

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

Coordination of Benefits

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

Providers must submit claims to other health insurers for consideration prior to billing Community Health Choice. A copy of the other health insurer's EOB/EOP or rejection letter should be

submitted with the claim to Community Health Choice. If we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the Provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue post-payment recovery.

Provider Payment Reconsideration

Claims Questions/Status

Providers can check claims status, Member eligibility, and a variety of other services online via our Provider Portal. You must sign up for this service. To learn more, visit CommunityHealthChoice.org. To check status of a claim payment, authorized Providers can either: Contact Provider Services during regular business hours:

Local: 713.295.2295 or Toll Free: 1.888.760.2600

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 713.295.2295.

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.

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

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

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

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the Provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization, as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the Provider will be contacted with the authorization number, and the Provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

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

Billing Members

Member Acknowledgement Statement

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

- A specific service or item is provided at the Member's request
- The Provider has obtained and kept a written Member Acknowledgement Statement signed by the client that states: "I understand that, in the opinion of (Provider's name) the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Program/Children's Health Insurance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary."

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

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

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

Private Pay Agreement

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

• A specific service or item is provided at the client's request.

• The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:

• “I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

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

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

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

Let us know if you think a doctor, dentist or pharmacist at a drug store, other healthcare Providers, or a person getting benefits is doing something wrong. Doing something wrong could be Fraud, Waste, or Abuse, which is against the law. For example, tell us if you think someone is:

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

To report Fraud, Waste, or Abuse, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/WafRep/to complete the online form; or
- You can report directly to your health plan:

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

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

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

Community Health Choice's Special Investigation Unit

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

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

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

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

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

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

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

Reporting Abuse, Neglect or Exploitation (ANE)

MEDICAID MANAGED CARE

Report suspected Abuse, Neglect and Exploitation:

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

Report to Health and Human Services (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHSC;
- Adult day care centers; or
- Licensed adult foster care

Providers Contact HHSC at 1-800-

458-9858.

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

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

Report to Local Law Enforcement:

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

Failure to Report or False Reporting:

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

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

STAR PROGRAM

STAR Program Objectives

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

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

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

STAR Covered Services

General Description

The following information provides an overview of benefits available to Community Health Choice Members enrolled in the STAR program. Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) or go to website TMHP.com for a comprehensive listing of limitations and exclusions that apply to each benefit category:

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through TMHP and are a non-capitated service)
- Behavioral health services, including:
    - Inpatient mental health services, including freestanding psychiatric facilities, psychiatric units of general acute care hospitals, and state-operated facilities
    - Psychiatric services
    - Outpatient mental health services
    - Counseling services
    - Outpatient chemical dependency services
    - Attention Deficit Hyperactivity Disorder (ADHD) services, including medications and follow- up care for children who have been prescribed ADHD medications
    - Detoxification services
- Birthing center services

- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early childhood intervention (ECI) services
- Emergency services
- Family planning services
- Home health services
- Hospital services (inpatient and outpatient)
- Laboratory services
- Medical checkups and Comprehensive Care Program (CCP) services for children (under 21) through the Texas Health Steps Program
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist or physician assistant in a licensed birthing center
- Prescription drugs, medications, and biologicals, including pharmacy-dispensed and Provider- administered outpatient drugs and biologicals
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Telehealth
- Telemedicine
- Telemonitoring to the extent covered by Texas Government Code §531.01276
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues
- Texas Health Steps
- Vision, including optometry and glasses (provided through a delegated entity)

All benefits are subject to the limitations and exclusions as outlined in the current Texas Medicaid Provider Procedures Manual (TMPPM).

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

Coordination with Non-Health Plan Covered Services (Non-Capitated Services)

STAR Members are eligible for the services described below. Community Health Choice and our network Providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM)

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation)
- HHS hospice services
- Admissions to inpatient mental facilities as a condition of probation
- For STAR, Texas Health Steps personal care services for Members birth through age 20
- HHSC contracted Providers of case management or service coordination services for individuals who have intellectual or developmental disabilities
- For Members who are prospectively enrolled in STAR from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are non-capitated services, except for a stay in a chemical dependency treatment facility.

Case Management for Children and Pregnant Women (CPW)

These changes are effective September 1, 2022.

Case Management for Children and Pregnant Women is a Medicaid State Plan benefit that assists children and pregnant women in

gaining access to necessary medical, social, educational, and other service needs related to the person's health condition, health

risk, or high-risk condition. Providers who render CPW services must be a Registered Nurse or Licensed Social Worker.

Community Health Choice will provide service coordination for CPW through a Case Manager. The Case Manager has the

responsibility for providing service coordination and care management to members. The Case Manager will work in conjunction

with members and their designated representatives and providers to determine needs through the use of assessment tools and

Service & Care Planning. A Case Manager can be reached at 713.295.2303 or 1.855.315.5386.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

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

Family Planning

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

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

Family Planning does not require an authorization.

Sterilization

In the event that a Community Health Choice STAR Medicaid Member desires sterilization as their method of family planning, the Family Planning Provider must complete all sections of the Sterilization Consent Form. The form is available in both Spanish and English on the TMHP website, TMHP.com. This form requires:

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

Breast Pump Coverage in Medicaid and CHIP

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

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

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

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

Texas Health Steps

THSteps Goals

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

THSteps Services

THSteps services include:

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

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

Periodicity Schedule

Medical checkups are covered for Members under 21 in accordance with the THSteps Periodicity Schedule. The medical checkup periodicity schedule specifies the ages that medical screens/checkups are to be performed and the required screening protocol. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM0 for detailed information. Medical checkups that are exceptions to the periodicity schedule are covered if they are medically necessary, the child has an environmental risk, when required to meet federal or state exam requirements, or when needed before a dental procedure requiring general anesthesia. Acceptance of THSteps medical checkups (or any other service) is voluntary. Acceptance or refusal of services does not affect eligibility for or benefits of any other Medicaid service.

Children of Migrant Farmworkers

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

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

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

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

Referral Guidelines

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

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

Reimbursement for Medical Checkups

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

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

Immunizations (based on the immunization schedule established by the Advisory Committee on Immunization Practices) are a federal/state-required component of a THSteps medical checkup. THSteps Providers are not reimbursed for the costs of vaccines administered during a medical

checkup, as vaccines are available free of charge to Providers through the Texas Vaccines for Children (TVFC) Program. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) or the Texas Department of State Health Services website for information on enrolling in the TVFC.

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

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

Documentation of completed Texas Health Steps components and elements

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

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

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

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening, and TB screening

- A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social, and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
- Mental health screening is required at each Texas Health Steps and includes behavioral, social, and emotional development. Effective July 1, 2018, maternal postpartum depression screening may be completed during an infant's Texas Health Steps checkup prior to the infant's first birthday. Providers may receive separate reimbursement, in addition to reimbursement for the checkup, when screening using a validated screening tool. A Provider may receive separate reimbursement only once per infant.
- Mental health screening is recommended annually for all clients who are 12 through 18 years of age. Providers may receive separate reimbursement, in addition to reimbursement for the checkup, when screening using a validated screening tool.

2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
   - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
   - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza, and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
   - The screening Provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
   - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
   - Providers may enroll, as applicable, as Texas Vaccines for Children Providers. For information, please visit https://DSHS.texas.gov/immunize/tvfc/.
4. **Laboratory tests**, as appropriate, that include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
   - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS

Laboratory Services Section in Austin. Providers must include detailed identifying information for all newborn Members and the Member's mother to allow DSHS to link the screens performed at the hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

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

5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers, and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents, and disease.
6. **Dental referral** every six months until the parent or caregiver reports a dental home is established.
    - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self- refer for dental care at any age.

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

Laboratory Tests

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

THSteps Provider Responsibilities

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

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

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

THSteps Screenings for Newborns

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

The goals of the Texas Newborn Screening Program are to ensure that:

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

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

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

The current Newborn Screening Panel consists of the following:

- CAH
- Hemoglobin SC disease
- PKU
- Sickle beta thalassemia Screens are due:
    - 1st screen on all babies at 24-48 hours
    - 2nd screen on all babies at 1-2 weeks
- Galactosemia
- (5) Amino acidopathies
- Hypothyroid
- (5) Fatty acid oxidation disorders
- Sickle cell disease
- (9) Organic acid disorders
- Sickle cell anemia
- Biotinidase deficiency
- Mail to DSHS within 24 hours of collection

Newborn Screening Lab website and Lab Supplies Web form:

DSHS.texas.gov/lab/mrs_forms.shtm#supplies

Reporting Immunizations

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

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

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

Website: DSHS.texas.gov/immunize/immtrac or E-mail: ImmTrac at ImmTrac@DSHS.state.tx.us.

THSteps Vision Screen

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

Vision Benefits for Children

THSteps/Medicaid Services provide diagnosis and treatment for vision problems, including eyeglasses for defects in vision.

The following eye examination and eyewear services are available for THSteps clients:

- One eye examination with refraction per state fiscal year (September 1–August 31) for the purpose of obtaining eyewear

Exception: The yearly eye exam limitation can be exceeded when the school nurse, teacher or parent requests an exam or if the exam is medically necessary.

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

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

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

THSteps Comprehensive Care Services

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

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

THSteps Quick Reference Guide

For the latest version of the Texas Health Steps Quick Reference Guide visit TMHP at: https://www.tmhp.com/programs/thsteps

Community Health Choice Panel Report

Your monthly panel reports help identify STAR Members who have THSteps checkups that are due and CHIP Members who are due Well-Child checkups. Panel reports are available via the Provider Portal.

Nonemergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb- to- curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone.

Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Community Health Choice's vendor, Access2Care, at 844.572.8194 for more information.

Health and Human Services (HHS) Hospice Services

HHS manages the statewide Hospice Program through Provider contracts with hospice agencies. Hospice services provide medical, social, and support services to eligible terminally ill patients upon approval, designed to keep clients comfortable and without pain during the last weeks and months before death. The HHS Hospice Program covers services related to the treatment of the client's terminal illness and certain physician services (not including treatments). This is not a service covered by Community Health Choice. Direct questions about the hospice program to the Hospice Program at 1.512.438.3550. Services unrelated to the terminal illness are the responsibility of Community Health Choice.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

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

Complaints and Appeals

STAR and STAR+PLUS Provider Complaints Process

Medicaid Provider Complaints Process

"Medicaid Complaint" means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. Complaint has the same meaning as grievance, as provided by 42 C.F.R. §438.400(b). Possible subjects for Complaints include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Member's rights regardless of whether remedial action is requested. Complaint includes the Member's right regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

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

Community Health Choice
Attn: Service Improvement
4888 Loop Central Dr Houston, TX 77081
Fax: 713.295.7036
Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Health Choice website CommunityHealthChoice.org.

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

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

Documentation

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

Provider Complaints Process to HHSC

After a Provider has exhausted the complaint process with Community Health Choice, a Provider has the right to file a complaint with HHSC to the following:

Texas Health and Human Services
Commission Re: Provider Complaint
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708

STAR Provider Appeals Process

Key Terms to Understand

- "**Appeal**" means the formal process by which a Member, or a Member's representative, requests
  a review of a Community Health Choice Action.
- "**Action**" is: (1) the denial or limited authorization of a requested Medicaid service, including type or level of service; (2) the reduction, suspension or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide a service in a timely manner; (5) the failure of Community Health Choice to act within the time frames of its contract with HHSC. An Adverse Determination is one type of Action.
- "**Adverse Determination**" is a decision by Community Health Choice that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary or appropriate.

Appeal of an Adverse Determination

A Provider may request an appeal of an Adverse Determination orally or in writing within 60 calendar days of the date of Community Health Choice's written notification of an Adverse Determination.

You will find a Provider Appeal Form on our website at https://provider.communityhealthchoice.org/resources/forms-and-guides/.

Community Health Choice
Attn: Medical Appeals
Toll Free: 1.888.760.2600
Fax: 713.295.7033

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

If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing Provider.

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

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

(a) a statement of the specific medical, dental, or contractual reasons for the resolution;
(b) the clinical basis for the decision;
(c) a description of or the source of the screening criteria that were utilized in making the determination;
(d) the professional specialty of the physician who made the determination;
(e) procedures for filing a complaint.

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

Expedited Appeals Procedures for Medical Necessity

You have the right to ask for an expedited appeal for a denial of emergency care, life-threatening conditions or continued hospitalization. This type of appeal is when you feel your patient's condition could get worse if you wait for the standard appeals process. You may request an expedited appeal, either orally or in writing. Community Health Choice will have a healthcare Provider review the appeal. This healthcare Provider will be someone who has not previously

reviewed the case and is of the same or a similar specialty as the healthcare Provider who would typically manage the medical or dental condition, procedure or treatment under review in the appeal.

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

Documentation

Community Health Choice will retain all Provider appeal documentation, including fax cover sheets, emails to and from Community Health Choice, and documentation of telephonic communication related to the appeal.

STAR Member Complaints and Appeals

STAR Member Complaint Process

How to File a Complaint

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

Community Health Choice Service Improvement 4888 Loop Central Dr Houston, Texas 77081

Or by calling Community Health Choice toll free at 1.888.760.2600.

Once a Member has gone through the Community Health Choice Complaint process, the Member can complain to HHSC, by calling toll free at 1.866.566.8989 or in writing, emailed to HPM_Complaints@hhs.texas.gov or mailed to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247
If you can get on the Internet, you can submit your complaint at: hhs.texas.gov/managed-care-help

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

Requirements and Time Frames for Filing a Complaint

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

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

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

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

What can I do if Community Health Choice denies or limits my Member's request for a Covered Service?

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

Member Appeal Process

How to File an Appeal

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

Community Health Choice
Member Appeals Coordinator
4888 Loop Central Dr Houston, TX 77081
Phone: 713.295.2294 or 1.888.760.2600
Fax: 713.295.7033

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

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

If the Member disagrees with the denial of the service and/or the payment of those services, the Member may file an appeal using the information detailed in this chapter.

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

Time Frame for Filing an Appeal

Members must file a request for appeal within 60 calendar days from receipt of a Notice of an Action. To ensure continuation of currently authorized services, a Member must file an appeal on or before the later of: (1) 10 calendar days following Community Health Choice’s mailing and notice of the action or (2) the intended effective date of the proposed action. The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

Time Frame for Resolution of an Appeal

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

How will I find out if services are denied?

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

When can a Member request a State Fair Hearing?

Members must go through the appeal process before requesting a State Fair Hearing. See “State Fair Hearing Information.”

Expedited Member MCO Appeal

Right to an Expedited Appeal

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

How to File an Expedited Appeal

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

Community Health Choice
Appeals Department
4888 Loop Central Dr Houston, TX 77081
Phone: 713.295.2295 or 1.888.760.2600
Fax: 713.295.7033

Community Health Choice will accept Expedited Appeals 24 hours a day, seven days a week. Requests for Expedited Appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal. An acknowledgement of the expedited appeal will be communicated to the requestor on the next business day.

Resolution Time Frame for an Expedited Appeal

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

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

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

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

1.) the Member requests an extension; or

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

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

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

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

External Medical Review Information

Can a Member ask for an External Medical Review?

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

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Community Health Choice by using the address or fax number at the top of the form.;
- Call Community Health Choice at 713.295.2294 or toll-free at 1.888.760.2600;
- Email Community Health Choice at Appeals@communityhealthchoice.org, or;
- Go in-person to a local HHSC office.

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.
The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.
Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing the Member can also request the Independent Review Organization to be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at 713.295.2294 or toll- free at 1.888.760.2600 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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

Can a Member ask for an emergency External Medical Review?

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

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

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

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

Or call Toll Free at 1.888.760.2600

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

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

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

STAR Member Eligibility and Added Benefits

STAR Member Eligibility Determination by HHSC

Community Health Choice provides health services for these STAR targeted client groups:

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

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

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

Adoption Assistance and Permanency Care Assistance (AAPCA)

Effective September 1, 2017, Adoption Assistance and Permanency Care Assistance (AAPCA) clients who currently receive Medicaid services through Medicaid fee-for-service will be moved into Managed Care Organizations (MCOs), like Community. Adoption Assistance clients are children who are adopted from foster care. Permanency Care Assistance clients are children who cannot be reunited with their parents and are placed with families who receive financial support to provide a permanent home. Members will be assigned to a specific Medicaid program (STAR or STAR Kids), based on health and income status. Community Health Choice does not participate in STAR Kids.
Members assigned to Community Health Choice will receive the same benefits as existing STAR Members. Members assigned to Community Health Choice will have the same Community Health Choice STAR ID card as existing STAR Members. Members that will be assigned to Community Health Choice (and subsequently may become your patients) do not receive Supplemental Security

Income (SSI), Medicare, or 1915(C) waiver services; do not have a disability as determined by the U.S. Social Security Administration or the State of Texas; and do not live in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID).

Span of Eligibility

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

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

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

Verifying Member Medicaid Eligibility

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

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling 1.800.252.8263. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

Texas Benefits Medicaid Card

Front of the Card

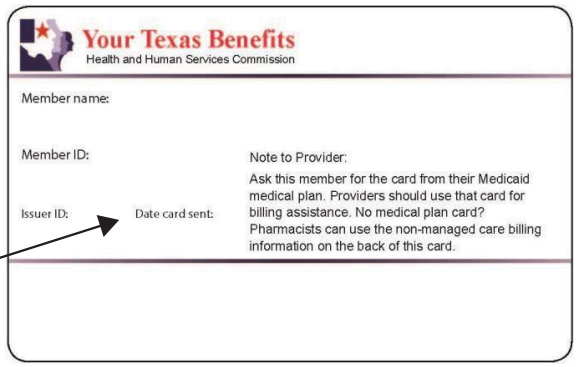
This is where your name appears

This is where Medicaid ID Number

This is HHSC's Agency ID number.

Doctors and other providers need this number

This is the date the card was sent to you

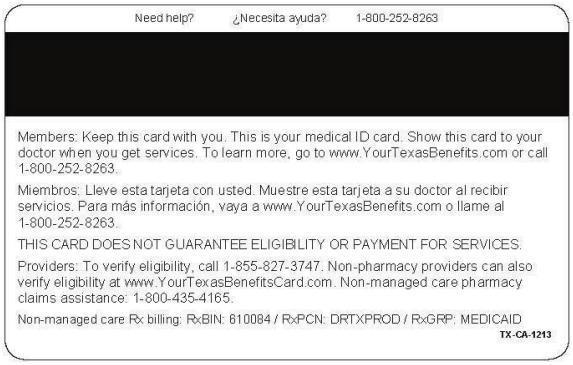


Back of the card:

This message is for you.

This reminds your doctor to make sure you are still in the Medicaid program before giving you services.

These messages help doctors and providers get paid for the Medicaid services they give you



Verifying Community Health Choice Member Eligibility

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

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

- Community Health Choice Online at CommunityHealthChoice.org. Complete the Community Health Choice Secure Access Application to become an authorized user.
- Call Community Health Choice Member Services to get more information.
- Community Health Choice Provider Services at 713.295.2295 or 1.888.760.2600. You can check eligibility, benefits and PCP selection.
- Providers may also contact the TMHP Automated Inquiry System (AIS) at

1.800.925.9126 and by visiting TexMedConnect Provider portal on the TMHP website at TMHP.com.

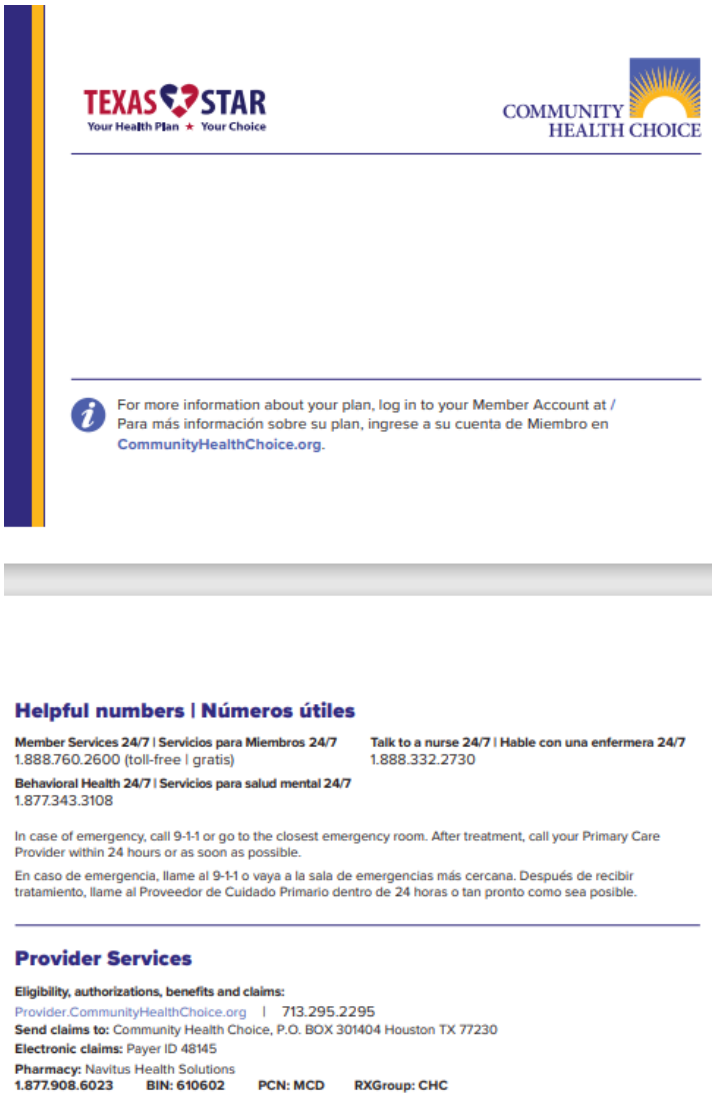
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only) Be sure to have the following information when you call or go to Community Health Choice Online:
    - Member's name
    - Member's ID number
    - Member's designated PCP

Community Health Choice Member ID Card

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

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

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



Member ID Card for Newborns

In the case of newborns, Community Health Choice will accept claims utilizing the mother's information then issue the newborn an ID card with the temporary "proxy" number. This is the mother's ID number with a suffix attached. Use this number on all claims until a state-issued Medicaid number is available.

When the state issues and informs Community Health Choice of the newborn's Medicaid ID number, we will reissue a new Community Health Choice Member ID card with the new Medicaid ID number. The Medicaid ID form will have "STAR Community Health Choice" printed in the upper right portion of the form. Each STAR Program Member in the household/case will appear on the form.

Immediately under the Member name, the name of the Member's plan will be printed. In addition,

there will be an indication if the Member is eligible for the Texas Health Steps Medical Screen or Dental Services Program.

Temporary Medicaid ID Verification 1027-A

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

Pharmacy Services

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

Member Selection/Assignment of a Primary Care Provider

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

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

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

Additional Benefits of the STAR Program

Spell-of-Illness Limitation

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

Unlimited Prescriptions

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

Annual Limit on Inpatient Services

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

STAR Value-Added Services

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

- **24-Hour Nurse Help line**: Members can call our Nurse Help line 24 hours a day, seven days a week toll free at 1.888.332.2730. A nurse will answer Members' healthcare questions and can help Members get the health care they need.
- **Extra Dental Benefits for Members 21 and older and Pregnant Women**: Two routine dental exams per year with teeth cleaning, x-rays (one annually), non-surgical extractions and emergency exams (limited)
- **Extra Vision Services**: Eligible Members, regardless of age, may elect to opt-out of the standard eyewear benefit and utilize $100 to use towards the purchase of non-standard eyeglasses OR contact lenses, including disposables and contact lens fitting fees every twenty- four (24) months, with the benefit period measured from the date of service. This is a total eyewear allowance which may be applied to the Member's choice of eyeglass frame/lenses/lens options or to contact lenses in lieu of eyeglasses (when contact lenses are chosen, the allowance is applied to the participating provider's retail cost for the contact lenses and professional services specific to contact lens wear, e.g., fitting, assessment and follow-up). Eyewear must have a prescription of at least + 0.50 diopter in at least one eye in order to qualify for coverage. Members who elect to purchase eyewear with a retail value greater than the $100 allowance are financially responsible for paying the participating provider's usual and customary (retail) cost of the difference between the cost of the eyewear selected and the $100 allowance.
- **Transportation Services**: Help getting a ride to a doctor's visit if unable to schedule with the NEMT provider due to time constraints for appointments or passenger limitations.
- **Disease Management**: Educational materials for Members who are enrolled in our Asthma and Diabetes Care Management Programs and/or Behavioral Case Management Programs.

- **Help for Members with** Asthma: One allergy-free pillowcase each year to Members enrolled in our Asthma Care Management Program. Member gets one pillowcase per year based on when Member received one before.
- **Extra Help for Pregnant Women**: $25 gift card for completing a prenatal checkup within 42 days of enrollment; $25 gift card for completing a timely postpartum checkup within 21-56 days after giving birth
- **Health and Wellness Services**: Up to $100 allowance towards an annual Baker Ripley membership in the Harris Service Area
- **Healthy Play and Exercise Programs**: $30 gift card each year for school-aged Member up to grade 12 who are in a school-sponsored extracurricular sports (athletic) program to pay for program fees, supplies or uniforms
- **Healthy Play and Exercise Programs**: $40 gift card each year for Members up to grade 12 who participates in a youth sports league (apart from extracurricular, school-sponsored activities)
- **Healthy Play and Exercise Programs**: Members age 6 years through 17 years who live in the Harris Service Area may join a participating location of the Boys and Girls Club in the Greater Houston area for free. Contact Community Health Choice for a list of locations.
- **Gift Card Program**:$10 gift card for each of up to six well-child checkups before turning 15 months old, plus a $25 bonus gift card for completing all six checkups, for a total of up to $85
- **Sports and School Physicals**: One each year for Members ages 4 through 19.

Long Lasting Reversible Contraception Products

Prescribers for Medicaid (STAR) and Healthy Texas Women are able to obtain long-acting reversible contraception (LARC) products only through a limited number of specialty pharmacies. For additional information, visit the Navitus website at https://txstarchip.navitus.com/pages/larc.aspx.

Hospitals

Procedure codes for LARCs may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum.

Procedure Codes

J7297, J7298, J7300, J7301, J7307

“Immediately postpartum” refers to insertion within 10 to 15 minutes of placental delivery, after vaginal or cesarean delivery, for intrauterine devices (IUDs) or insertion prior to discharge for implantable contraceptive capsules.

When seeking reimbursement for an IUD or implantable contraceptive capsule inserted immediately postpartum, hospital/facility Providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

FQHCs

FQHCs may receive reimbursement for the following procedure codes in addition to the FQHC encounter payment.

Procedure Codes

J7297, J7298, J7300, J7301, J7307

When seeking reimbursement for an IUD or implantable contraceptive capsule, Providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations.

Healthy Texas Women

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185% of the federal poverty level). An application must be submitted for services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:

Healthy Texas Women Program

P.O. Box 149021

Austin, TX 78714-9021

Phone: 1-800-335-8957

Website: https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women Fax: (toll-free) 1-866-993-9971

STAR and STAR PLUS Member Rights and Responsibilities

STAR and STAR PLUS Member Rights

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

e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need
    b. Get medical care in a timely manner
    c. Be able to get in and out of a health care Provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your Providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them
7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member's Right to Designate An OB/GYN

Community Health Choice allows the Member to pick an OB/GYN but this doctor must be in the same network as the Member's PCP.

ATTENTION FEMALE MEMBERS

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

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

STAR and STAR PLUS Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program

b. Ask questions if you do not understand your rights

c. Learn what choices of health plans are available in your area

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

a. Learn and follow your health plan's rules and Medicaid rules

b. Choose your health plan and a PCP quickly

c. Make any changes in your health plan and PCP in the ways established by Medicaid and by the health plan

d. Keep your scheduled appointments

e. Cancel appointments in advance when you cannot keep them

f. Always contact your PCP first for your non-emergency medical needs

g. Be sure you have approval from your PCP before going to a specialist

h. Understand when you should and should not go to the emergency room

3. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:

a. Tell your PCP about your health

b. Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated

c. Help your Providers get your medical records

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

a. Work as a team with your Provider in deciding what health care is best for you

b. Understand how the things you do can affect your health

c. Do the best you can to stay healthy

d. Treat Providers and staff with respect

e. Talk to your Provider about all of your

medications Additional Member Responsibilities while

using NEMT Services:

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.

5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

Billing Members

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

STAR and STAR PLUS Enrollment and Disenrollment from Community Health Choice

Enrollment

Pregnant Women

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

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

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

Newborns

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

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

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

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

Automatic Reenrollment

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

Disenrollment

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

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

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

Members requesting disenrollment from STAR are required to provide medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

HHSC will make the final determination regarding Member requests for dis-enrollment from STAR.

Providers are prohibited from taking retaliatory action against Members.

CHIP PROGRAM

CHIP Program Objectives

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

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

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

CHIP Covered Services

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

Co-pays apply until a family reaches its specific cost-sharing

maximum. There is no spell-of-illness limitation.

Covered Benefits	Limitations	Co-Payments
Inpatient General Acute and Inpatient Rehabilitation Hospital Services • Hospital-provided physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets	• Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition • Requires authorization for in-network or out-of-	See Card for copayment per admission.

Covered Benefits	Limitations	Co-Payments
• Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care	network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by Cesarean section	
• In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non- viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: o dilation and curettage (D&C) procedures; o appropriate Provider-administered medications; o ultrasounds; and o histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical	•	

Covered Benefits	Limitations	Co-Payments
intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip or palate; ○ severe skeletal and/or congenital deviations; ○ severe facial asymmetry including skeletal and/or congenital origins; and ○ non-functional full Class II bite relationship and non-functional Class III bite relationship as defined by the American Association of Oral and Maxillofacial Surgeons' classification of occlusion or malocclusion. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: ○ all stages of reconstruction on the affected breast; surgery and reconstruction on the other breast to produce symmetrical appearance		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and physician prescription • 60 days per 12-month period limit	
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Healthcare Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • X-ray, imaging, and radiological tests (technical component)	• Requires prior authorization and physician prescription	None for preventive services. $0 copayment for generic drugs. See Card for copayment for brand drugs.

Covered Benefits	Limitations	Co-Payments

• Laboratory and pathology services (technical component)
• Machine diagnostic tests
• Ambulatory surgical facility services
• Drugs, medications and biologicals
• Casts, splints, dressings
• Preventive health services
• Physical, occupational and speech therapy
• Renal dialysis
• Respiratory services
• Radiation and chemotherapy
• Blood or blood products that are not provided free-of charge to the patient and the administration of these products
• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a li-censed ambulatory surgical facility
• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  ○ dilation and curettage (D&C) procedures;
  ○ appropriate Provider-administered medications;
  ○ ultrasounds; and
  ○ histological examination of tissue samples.
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  ○ cleft lip and/or palate; or
  ○ severe traumatic, skeletal and/or congenital cranio-facial deviations; or
  ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
• Surgical implants
• Other artificial aids including surgical implants		

Covered Benefits	Limitations	Co-Payments

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

Physician/Physician Extender Professional Services include, but are not limited to the following:
• American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
• Physician office visits, in-patient and outpatient services
• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
• Medications, biologicals and materials administered in physician's office
• Allergy testing, serum and injections
• Professional component (in/outpatient) of surgical services, including:
  ○ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
  ○ Administration of anesthesia by physician (other than surgeon) or
  ○ CRNA
  ○ Second surgical opinions
  ○ Same-day surgery performed in a Hospital without an overnight stay
  ○ Invasive diagnostic procedures such as endoscopic examinations
	• Requires authorization for specialty services	See Card for copayment for office visit.
		Co-pays do not apply to preventive visits or to prenatal visits after the first visit.

Covered Benefits	Limitations	Co-Payments

• Hospital-based physician services (including physician-performed technical and interpretive components)
• Physician and professional services for a mastectomy and breast reconstruction include:
  ○ all stages of reconstruction on the affected breast;
  ○ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  ○ surgery and reconstruction on the other breast to produce symmetrical appearance; and
treatment of physical complications from the mastectomy and treatment of lymphedemas.		

• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section
• Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation
• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  ○ dilation and curettage (D&C) procedures;
  ○ appropriate Provider-administered medications;
  ○ ultrasounds; and
  ○ histological examination of tissue samples.
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:		

Covered Benefits	Limitations	Co-Payments
○ cleft lip and/or palate; or ○ severe traumatic, skeletal and/or congenital cranio-facial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit Diagnosis-specific disposable medical supplies, including diagnosis- specific prescribed specialty formula and dietary supplements	• May require prior authorization and physician prescription $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap)	None
H**ome and Community Health Services are provided in the home and community, including, but not limited to:** • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.)	• Requires prior authorization and physician prescription • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker.	None

Covered Benefits	Limitations	Co-Payments
• Home health aide when included as part of a plan of care during a period that skilled visits have been approved Speech, physical and occupational therapies	• Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to: • Neuropsychological and psychological testing	• Requires prior authorization for nonemergency services. • Does not require PCP referral. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	See Card for inpatient copayment.

Covered Benefits	Limitations	Co-Payments
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings • (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing. • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) Skills training (psycho-educational skill development)	• May require prior authorization • Does not require PCP referral • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • Qualified Mental Health • Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division1), §412.303(48). QMHP-CSs shall be Providers working through a DSHS-contracted Local Mental Health	See Card for copayment for office visit.

Covered Benefits	Limitations	Co-Payments
	Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient Substance Abuse Treatment Services include, but are not limited to: • Services for Inpatient and Residential Treatment Programs including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	• Requires prior authorization for non-emergency services • Does not require PCP referral	See Card for inpatient copayment.
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician Providers, such as screening, assessment, and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization Intensive outpatient services are defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at	• Requires prior authorization Does not require PCP referral	See Card copayment for office visit.

Covered Benefits	Limitations	Co-Payments
least 10 hours per week for four to 12 weeks, but less than 24 hours per day. Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.		
Rehabilitation Services Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include but are not limited to the following: • Physical, occupational and speech therapy Developmental assessment	Requires prior authorization and physician prescription	None
Hospice Care Services Services include but are not limited to: • Palliative care, including medical and support services for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	• Requires authorization and physician prescription • Services apply to the hospice diagnosis • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at any time.	None
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Medical Conditions, Emergency Behavioral Health Conditions or labor and delivery. Covered services include: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24	• Requires authorization for post-stabilization services	See Card for copayment for non-emergency ER

Covered Benefits	Limitations	Co-Payments
hours a day, 7 days a week, both by in-network and out-of-network Providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts		
Transplants Covered services include: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses	• Requires authorization	None
Vision Benefit Covered services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period The health plan may reasonably limit the cost of the frames/lenses.	• May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye	See Card for copayment for office visit.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation.	• May require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) • May require authorization for additional visits	See Card for copayment for office visit.

Covered Benefits	Limitations	Co-Payments
Tobacco Cessation Program Covered up to $100 for a 12-month period limit for a plan approved program	• May require authorization • Health Plan defines plan- approved program • May be subject to formulary requirements	None

Telehealth, Telemedicine and Telemonitoring are also covered benefits under the CHIP Program.

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

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

CHIP Member Prescriptions

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

CHIP Value-Added Services and Extra Benefits

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

- **24-Hour Nurse Help Line**: Members can call our Nurse Help Line 24 hours a day, seven days a week toll free at 1.888.332.2730. A nurse will answer Members' healthcare questions and can help Members get the health care they need.
- **Extra Vision Services:** Eligible Members may elect to opt-out of the standard eyewear benefit and utilize $100 to use towards the purchase of nonstandard eyeglasses OR contact lenses, including disposables and contact lens fitting fees every twelve (12) months, with the benefit period measured from the date of service. This is a total eyewear allowance which may be applied to the Member's choice of eyeglass frame/lenses/lens options or to contact lenses in lieu of eyeglasses (when contact lenses are chosen, the allowance is applied to the participating provider's retail cost for the contact lenses and professional services specific to contact lens wear, e.g., fitting, assessment and follow-up). Eyewear must have a prescription of at least +
  0.50 diopter in at least one eye in order to qualify for coverage. Members who elect to purchase eyewear with a retail value greater than the $100 allowance are financially responsible for paying the participating provider's usual and customary (retail) cost of the difference between the cost of the eyewear selected and the $100 allowance.
- **Transportation Services**: Help with getting a ride to a doctor's visit.
- **Sports and School Physicals**: One each year for Members ages 4 through 19
- **Disease Management**: Educational materials for Members who are enrolled in our Asthma and Diabetes Care Management Programs and/or Behavioral Health Case Management Programs.
- **Help for Members with Asthma:** Asthma educational materials and one allergy-free pillowcase each year to Members enrolled in our Asthma Care Management Program. Member gets one pillowcase per year based on when Member received one before.
- **Health and Wellness Services**: Up to $100 allowance towards an annual Baker Ripley membership in the Harris Service Area
- **Healthy Play and Exercise Programs**: $30 gift card each year for school-aged Member up to grade 12 who are in a school-sponsored extracurricular sports (athletic) program to pay for program fees, supplies, or uniforms.

- **Healthy Play and Exercise Programs:** $40 gift card each year for Members up to grade 12 who participate in a youth sports league (apart from extracurricular, school sponsored activities)
- **Healthy Play and Exercise Programs**: Members age 6 years through 17 years who live in the Harris Service Area may join a participating location of the Boys and Girls Club in the Greater Houston area for free. Contact Community Health Choice for a list of locations.

Health Education Program

Community Health Choice provides health fairs and wellness screenings, to help Community Health Choice Members learn to stay healthy.

- Community Health Choice's Care Management Program to Members with diabetes, asthma or high-risk pregnancies. Community Health Choice nurses will help Members learn about these illnesses.
- Answer Members' questions
- Give Members advice
- Send materials to Members
- Find the best doctors to help Members
- Make appointments for Members

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

Assistance with CHIP Renewal

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

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

Members can also call the CHIP Help Line at 1.800.647.6558, 2-1-1 or Community Health Choice Member Services to receive a CHIP application.

CHIP Exclusions from Covered Services

- Applied Behavior Analysis (ABA) Therapy
- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses or abnormalities related to the reproductive system

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

- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy or speech therapy services are not covered except when ordered by a physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Educational testing and treatment, evaluation and treatment of learning disabilities

Coordination with Non-CHIP Covered Services (non-capitated services)

Community Health Choice is not responsible for providing the services listed below but is responsible for appropriate referrals for these services. We will enlist the involvement of community organizations that may not provide CHIP-covered services but are otherwise important to the health and well-being of Members. We will make a best effort to establish relationships with these community organizations to make referrals. CHIP Members who meet the criteria for children with complex special healthcare needs (CSHCN) have access to community organizations for assistance with referrals and services for their complex healthcare needs. These organizations may include:

- Texas agency-administered programs and case management services
- Essential public health services

Our case managers can offer assistance with coordination of care for these Members.

Complaints and Appeals

CHIP Provider Complaints Process

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

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

Community Health Choice
Attn: Service Improvement
4888 Loop Central Dr -Houston, TX 77081 Fax: 713 .295.7054
Email: ServiceImprovement@CommunityHealthChoice.org

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

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

Documentation

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

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through Community Health Choice's complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 149091, Austin, Texas 78714- 9091. Complaints to the Texas Department of Insurance may also be filed electronically at TDI.state.tx.us.

CHIP Provider Appeals Process Key Terms to Understand

"Appeal" means the formal process by which Community Health Choice addresses adverse determinations.

"Adverse Determination" is a decision by Community Health Choice that a service furnished to a Member, or proposed to be furnished to a Member, is not medically necessary, experimental/investigational, or appropriate.

Appeal of an Adverse Determination

A Provider may request an appeal of an Adverse Determination orally or in writing within 30 calendar days of the date on Community Health Choice's written notification of an Adverse Determination.

Provider appeals must be in writing and accompanied by complete medical records. Appeals can be submitted through the Provider Portal on the Community Health Choice website at CommunityHealthChoice.org. You may request your appeal verbally or in writing:

Phone: 713.295.2294
Toll Free: 1.888.760.2600
Fax: 713.295.7033

If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing Provider.

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

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

(a) a statement of the specific medical, dental, or contractual reasons for the resolution;
(b) the clinical basis for the decision;
(c) a description of or the source of the screening criteria that were utilized in making the determination;
(d) the professional specialty of the physician who made the determination;
(e) procedures for filing a complaint.

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

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

Expedited Appeals Procedures for Medical Necessity

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

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

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

You also have the right to file a complaint about this process. To file a complaint, please contact Community Health Choice at:

Community Health Choice
Attn: Service Improvement
4888 Loop Central Dr Houston, TX 77081
Phone: 713.295.2294
Toll Free: 1.888.760.2600
Email: ServiceImprovement@CommunityHealthChoice.org

Community Health Choice must resolve your complaint within thirty (30) days.

Documentation

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

Independent Review Organization (IRO)

If the appeal of the Adverse Determination is denied, you have the right to request a review of an appeal by an approved Independent Review Organization (IRO). When Community Health Choice denies the appeal, you will receive information on how to request an IRO review of the denial and

the forms that must be completed and returned to begin the independent review process. The IRO will complete its review within 20 days of receipt of the request for IRO review. Request for IRO review, including the IRO form (LHL009), should be submitted to:

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

Phone: 713.295.2294
Toll Free: 1.888.760.2600
Fax: 713.295.7033

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

When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

Filing Appeals with the Texas Department of Insurance

Any person, including persons who have attempted to resolve appeals through Community Health Choice's appeal system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, TX 78714-9091. Appeals to the Texas Department of Insurance may also be filed electronically at TDI.state.tx.us.

CHIP Member Complaints and Appeals

CHIP Member Complaints Process How to File a Complaint

Members, or their authorized representatives, may file an oral or written complaint with Community Health Choice. Members may make complaints to Community Health Choice in writing, sent to the following address:

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

Phone: 713.295.2294

Or by calling Community Health Choice toll free at 1.888.760.2600.

Members should provide as much detail as possible describing their complaint. If Providers are involved, the name(s) of each Provider and, if services are involved, a description of the services and the date(s) of service. If the complaint is given orally, Community Health Choice will mail a one- page Complaint Form to the Member. The Member should complete and return the Complaint Form to Community Health Choice as soon as possible for prompt resolution.

Can someone from Community Health Choice help my Member file a complaint?

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

Requirements and Time Frames for Filing a Complaint

Members, or their representatives, may file a complaint at any time. Community Health Choice will, no later than the fifth business day after the date of the receipt of the complaint, send to the Member a letter acknowledging the date the complaint was received. If the complaint was received orally, Community Health Choice will include a one-page Complaint Form stating that the Complaint Form should be returned to Community Health Choice for prompt resolution.

After Community Health Choice receives the complaint, Community Health Choice will investigate and send Member a Resolution Letter. The total time for acknowledging, investigating and resolving Member complaints will not exceed 30 calendar days after the date Community Health Choice receives the Member complaint.

Member complaints concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of the Member complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Members may use the appeals process to resolve a dispute regarding the resolution of a Member complaint.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through Community Health Choice's appeal system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149091, Austin, Texas 78714-9091. Appeals to the Texas Department of Insurance may also be filed electronically at TDI.state.tx.us.

CHIP Member Appeals Process

If the Member complaint is not resolved to the Member's satisfaction, the Member has the right either to appear in person before a Complaint Appeal Panel where the Member normally receives healthcare services, unless another site is agreed to by the Member, or to address a written appeal to the Complaint Appeal Panel. Community Health Choice will complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for complaint appeal.

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

Phone: 713.295.2294
Toll Free: 1.888.760.2600
TDD: 1.800.518.1655

Community Health Choice will send an Acknowledgment Letter to Member not later than the fifth day after the date of receipt of the request of the complaint appeal.

Community Health Choice will appoint Members to the Complaint Appeal Panel, which will advise Community Health Choice on the resolution of the dispute. The Complaint Appeal Panel will be composed of an equal number of Community Health Choice staff, physicians or other Providers, and enrollees. A member of the Complaint Appeal Panel may not have been previously involved in the disputed decision.

Not later than the fifth business day before the scheduled meeting of the Complaint Appeal Panel, unless Member agrees otherwise, Community Health Choice will provide to Member or Member's designated representative:

a) any documentation to be presented to the panel by Community Health Choice's staff;

b) the specialization of any physicians or Providers consulted during the investigation; and

c) the name and affiliation of each of Community Health Choice's representatives on the panel.

Member, or Member's designated representative if Member is a minor or disabled, are entitled to: (a) appear in person before the Complaint Appeal Panel; (b) present alternative expert testimony; and (c) request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after Member's request for appeal.

Due to the ongoing emergency or continued hospital stay, and at Member's request, Community Health Choice will provide, in lieu of a Complaint Appeal Panel, a review by a physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal.

Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

What can I do if Community Health Choice denies or limits my Patient's request for a Covered Service?

A Member has the right to appeal any services that have been denied by Community Health Choice that do not meet the criteria of medical necessity or experimental/investigational. A denial of this type is called an "Adverse Determination."

An Appeal is considered a disagreement with an Adverse Determination. A Member can request an appeal orally or in writing.

How to File an Appeal

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

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

Fax: 713.295.7033

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

If a Member files a written appeal, Community Health Choice will send the requestor a written acknowledgement within five business days. If a Member files an oral appeal, Community Health Choice will send a written acknowledgement and an Appeal Form within five business days. The requestor must return the Appeal Form to document the appeal in writing. If a Member or his/ her

representative requests an expedited resolution of an appeal, Community Health Choice will follow the steps in the subsection “Expedited MCO Appeals.”

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

Time Frame for Filing an Appeal

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

Time Frame for Resolution of an Appeal

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

Can someone from Community Health Choice help the Member file an appeal?

For assistance with an appeal or expedited appeal, call Member Services toll free 1.888.760.2600, and an appeals coordinator will assist them with the appeal.

Expedited Member MCO Appeal Right to an Expedited Appeal

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

How to File an Expedited Appeal

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

Community Health Choice
Appeals Department
4888 Loop Central Dr.
Houston, TX 77081

Phone: 713.295.2295 or 1.888.760.2600
Fax: 713.295.7033

Community Health Choice will accept expedited appeals 24 hours a day, seven days a week. Requests for expedited appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal. An acknowledgement of the expedited appeal will be communicated to the requestor the next business day.

Resolution Time Frame for an Expedited Appeal

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

1. in accordance with the medical immediacy of the case; and
2. not later than one business day after Community Health Choice receives the request for the expedited appeal.

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

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

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

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

If Community Health Choice determines that a Member's appeal request does not follow the definition of expedited appeal, it will treat the appeal as a standard appeal. Community Health Choice shall make a reasonable effort to notify the requestor that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

Who can help me file an Expedited Appeal?

For assistance with an appeal or expedited appeal, call Member Services toll free 1.888.760.2600.

How do I request a review by IRO and what are the timeframes?

An Independent Review Organization (IRO) makes decisions on medical necessity and appropriateness of care. If the appeal of the Adverse Determination is denied, a Member, Member's designated representative or Member's physician or Provider of record have the right to request a review of that decision by an IRO. When Community Health Choice or Community Health Choice's Utilization Review Agent deny the appeal, the Member, Member's designated representative or Member's physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a life-threatening condition, the Member is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In life-threatening situations, Member, Member's designated representative or Member's physician or Provider of record may contact Community Health Choice or Community Health Choice's Utilization Review Agent by telephone to request the review by the IRO, and Community Health Choice or Community Health Choice's Utilization Review Agent will provide the required information.

Members may call Member Services at 713.285.2294 or 1.888.760.2600 and ask for an "Independent Review Organization Form." When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

Community Health Choice will immediately notify the IRO's managing entity of the request for the IRO review. The IRO's managing entity will assign the case to an IRO within one business day. If the IRO requests any information, Community Health Choice must provide the information to the managing entity within three business days. The IRO must reach a decision within 15 days, but no later than 20 days after the IRO receives the case from the IRO's managing entity. In cases involving life-threatening conditions, the IRO must reach a decision within five days but no later than eight days after the IRO receives the case from the IRO's managing entity.

When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

An IRO review is not available if Community Health Choice denies payment for a non-covered service such as cosmetic surgery. IRO review is also not available if a Member has already received treatment, and Community Health Choice determined that the treatment was not medically necessary.

The appeal procedures described above do not prohibit Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment or other relief available under law, if Member believes that the requirement of completing the appeal and review process places Member's health in serious jeopardy.

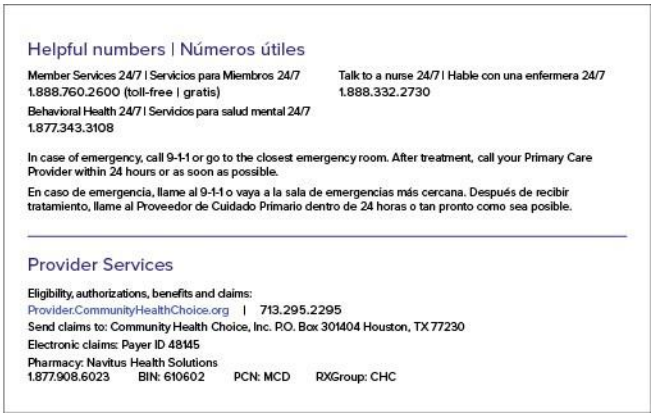
CHIP Member Eligibility and Added Benefits

CHIP Member Eligibility

Children who enroll in CHIP receive 12 months of continuous coverage. Families must re-enroll annually. Eligibility for enrollment in CHIP is determined by the HHSC's Administrative Services Contractor.

Verifying Eligibility Member ID Card

All Community Health Choice Members are issued a Community Health Choice Member ID Card. When verifying Member eligibility, ask for your patient's Community Health Choice CHIP Member ID Card. Make a copy of both sides of the card for the Member's file. Before providing services, verify that you have received an authorization number for inpatient or outpatient services. Failure to obtain authorization may result in a denial by Community Health Choice.



Eligibility Verification

To verify Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community Health Choice online at CommunityHealthChoice.org. You will need to fill out the Community Health Choice Secure Access Application to become an authorized user. Call Provider Services to get more information. You can check eligibility, benefits, and PCP selection online.
- Providers can receive eligibility information by calling the CHIP Provider Eligibility Hotline Monday through Friday 8:00 a.m. to 5:00 p.m. (Central Time). The hotline number is 1.800.645.7164. Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently an enrolled CHIP Member or receive an automated response if the Provider has a CHIP Member ID number.
- Community Health Choice Provider Services at 713.295.2295 or 1.888.760.2600.
- Electronic eligibility verification, e.g., NCPDP E1 Transaction (for pharmacies only)

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

- Member's name
- Member's identification number
- Member's designated PCP

Member Selection/Assignment of a Primary Care Provider

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

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

Re-Enrollment

Community Health Choice offers personal assistance at renewal time for Community Health Choice Members. Keeping benefits active is vital, and the renewal process can be confusing. Community Health Choice offers meetings and personal help at this difficult time.

If Community Health Choice Members need assistance with re-enrollment or applying, please have them contact Community Health Choice at 713.295.2222 or 1.877.635.6736 for assistance.

Pregnant Members (Including Pregnant Teens) and Infants

Providers must contact Community Health Choice immediately when a pregnant CHIP or Medicaid Member is identified.

When Community Health Choice receives notice from the guardian of the Member, the Member, or the Member's physician or Provider that a pregnancy has been diagnosed, Community Health Choice will notify the HHSC Administrative Services Organization. Depending on the Member's income and family size, the HHSC Administrative Service Organization may notify Member's guardian or Member about Member's potential eligibility for Medicaid and of Member's ability to apply for Medicaid. In that situation, the administrator will also provide appropriate resource information. A Member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If Member is not eligible for Medicaid, the Administrator will extend Member's eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the month of the baby's birth.

Newborns born to CHIP Members are automatically enrolled in the mother's CHIP plan. Infants who are Medicaid-eligible are not eligible for CHIP.

For this reason, it is critical that Providers notify Community Health Choice immediately upon learning about a CHIP Member's pregnancy and/or delivery.

CHIP Member Rights and Responsibilities

CHIP Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other Providers.
2. Your health plan must tell you if they use a "limited Provider network." This is a group of doctors and other Providers who only refer patients to other doctors who are in the same group. "Limited Provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's PCP and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other Providers in your health plan and their addresses.
6. You have a right to pick from a list of health care Providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's PCP. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her PCP and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co- payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other Providers.
16. You have the right to talk to your child's doctors and other Providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals, and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member's Right to Designate an OB/GYN (Applies to CHIP ONLY)

Community Health Choice allows the Member to pick an OB/GYN, but this doctor must be in the same network as the Member's PCP.

ATTENTION FEMALE MEMBERS

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

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

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other Providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other Providers co- payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care Providers, other Members or health plans.
9. Talk to your child's Provider about all of your child's medications.

Billing Members

HHSC rules prohibit Providers from balance billing CHIP Members (See TAC §370.453). Specifically, HHSC rules require Providers of services to CHIP Members to accept payment received for covered services as payment in full, and prohibits Providers from billing the CHIP Member, the CHIP Member's family or the CHIP Member's guardians for any remaining balances for covered services rendered. HHSC balance billing rules apply to network Providers and non-network Providers of authorized services.

Providers may only charge CHIP Members the copayment amounts authorized or services that are not covered under CHIP.

Providers are responsible for collecting all CHIP Member co-payments at the time of service.

Providers may only charge CHIP Members the copayment amounts authorized.

Providers are responsible for collecting all CHIP Member co-payments at the time of service.

Co-payments that families must pay vary according to their income level. Except for costs associated with unauthorized nonemergency services provided to a Member by out-of-network Providers and for non-covered services, the co-payments outlined in the CHIP cost-sharing table in the HHSC Uniform Managed Care Manual are the only amounts that a Provider may collect from a CHIP-eligible family. No co-payments apply, at any income level, to CHIP Members who are Native Americans or Alaskan Natives. Additionally, for CHIP Members there is no cost-sharing on benefits for well-child or well- baby visits or immunizations, preventative services, and pregnancy-related services.

The CHIP Member will not be responsible for any payment for medically necessary covered services, other than HHSC-specified co-payments for CHIP Members, where applicable.

CHIP Member Cost-Sharing Schedule

The table on the following page lists the co-pay schedule according to family income. Co-payments for medical services or prescription drugs are paid to the healthcare Provider at the time of service. No co-payments are paid for preventive care such as well-child or well-baby visits or immunizations. No copayments are paid for any pregnancy-related services.

CHIP Cost-Sharing

CHIP Cost-Sharing	
Effective July 1, 2022	
Enrollment Fees (for 12-month enrollment period):	Charge
At or below 151% of FPL* or otherwise exempt from cost-sharing.	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	Charge
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	Charge
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	Charge
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$25
Non-Emergency ER	$75

Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$125
Cost-sharing Cap	5% (of family's income)**

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

**Per 12-month term of coverage.

***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

CHIP Member Enrollment and Disenrollment from Community Health Choice

Enrollment/Re-Enrollment

Children who enroll in CHIP receive 12 months continuous coverage. Families must re-enroll their children annually. Eligibility for enrollment in CHIP is determined by the HHSC's Administrative Services Contractor.

When Does an Enrolled Child Become Covered?

Enrollment in CHIP will begin on the first day of the month after eligibility is determined. A child may be subject to a waiting period if the coverage lapses or if the child is moving from private insurance to CHIP coverage.

Paying for Enrolled Child's Coverage

If payment of an enrollment fee is required for the child's CHIP coverage, the fee must be paid before the child can be enrolled in CHIP. Enrollment fees are the responsibility of the Member. Enrollment fees should never be sent to Community Health Choice but directly to the state's enrollment broker.

Disenrollment

Disenrollment Due to Loss of CHIP Eligibility

Disenrollment may occur if a Member loses CHIP eligibility. A CHIP Member may lose CHIP eligibility for the following reasons:

- "Aging-out" when Member turns 19
- Failure to re-enroll by the end of the 12-month coverage period
- Change in health insurance status, i.e., a Member enrolls in an employer-sponsored health plan
- Death of a Member
- Member permanently moves out of the state
- Member is enrolled in Medicaid
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost- sharing under the current health plan totaled 10 percent or more of the family's gross income
- Child's parent or authorized representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
- Child's parent or authorized representative requests (in writing) the voluntary disenrollment of a child

Disenrollment by Community Health Choice

Your child may be disenrolled by US, subject to approval by the HHSC, for the following reasons:

- Fraud or intentional material misrepresentation made by a Member after 15 days written notice;
- Fraud in the use of services or facilities after 15 days written notice;
- Misconduct that is detrimental to safe plan operations and the delivery of services;
- Failure to establish a satisfactory patient physician/Provider relationship so long as we have, in good faith, provided the Member the opportunity to select an alternative participating physician or Provider. We will notify the Member in writing 30 days in advance that we consider the patient-physician/Provider relationship to be unsatisfactory and will specify the changes that are necessary to avoid disenrollment. If such changes are not made, coverage may be cancelled at the end of 30 days; and
- Child no longer lives or resides in the service area.

Community Health Choice must notify the Member of Community Health Choice's decision to disenroll the Member if all reasonable measures have failed to remedy the situation.

If the Member disagrees with the decision to disenroll the Member from Community Health Choice, Community Health Choice must notify the Member of the availability of the complaint procedure.

Community Health Choice will not disenroll a Member based on a change in the Member's health status or because of the amount of medically necessary services that are used to treat the Member's condition.

Providers may not take retaliatory action against Members.

Health Plan Changes

Members are allowed to make health plan changes under the following circumstances:

- For any reason within 90 days of enrollment in CHIP;
- If the Member moves to a different service delivery area;
- For cause at any time; and
- During the annual re-enrollment

period. HHSC will make the final

decision.

CHIP PERINATAL PROGRAM

CHIP Perinatal Program Objectives

CHIP Perinatal is designed for pregnant women who have a household income greater than 198% of the federal poverty level (FPL) and at or below 202% of the FPL and do not qualify for Medicaid due to immigration status. This program was authorized by the Texas Legislature as an extension of the CHIP Program for women who cannot qualify for Medicaid, traditionally served by Title V Program.

The objectives of the program include:

- Expedite enrollment to improve prenatal care and pregnancy outcomes
- Extending CHIP services to unborn children of non-Medicaid eligible women and enroll the unborn child in CHIP

Women who are U.S. citizens or qualified immigrants with household income at or below 198 percent of the FPL may be eligible for coverage under Medicaid's Pregnant Women program.

How the Program Works

The expectant mother will enroll by completing an application or by calling 2-1-1 for assistance. The mother will be determined eligible, and the 12 months of continuous coverage will begin based on her effective date. Coverage for the expectant mother is limited to prenatal care benefits, including up to 20 prenatal visits, physician services, laboratory and radiological services, and prescription drugs.

For mothers below 198% of FPL, hospital/facility charges related to labor with delivery will be covered by Texas Emergency Medicaid. Community Health Choice will be responsible for professional fees for the mother only. For mothers between 199% to 202% of FPL, hospital/facility charges related to labor with delivery and professional fees will be paid by Community Health Choice. All payments are subject to Community Health Choice's utilization review requirements and contract requirements. Once a child is discharged from the initial hospital admission, the child receives the traditional CHIP benefit package, or Medicaid, depending on their income. CHIP or Medicaid benefits include regular checkups, immunizations, and prescriptions for the baby after he or she leaves the hospital.

Depending on income, the newborn may get Medicaid from birth to their first birthday. Most CHIP perinatal infants qualify for Medicaid. If the baby is eligible to get Medicaid, the mother will receive a letter and Form H3038-P, CHIP Perinatal-Emergency Medical Services Certification, in the mail before delivery.

Enrollees in the CHIP Perinatal Program are exempt from all enrollment fees, waiting periods, and cost sharing.

CHIP Perinatal Covered Services

Covered CHIP Perinatal services must meet the definition of Medically Necessary covered services as defined by the Health and Human Services Commission. There is no lifetime maximum of benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members.

There is no spell-of-illness limitation for CHIP Perinate Newborns.

Covered Benefits	Limitations	Co-Payments

Inpatient General Acute Services include:
• Covered medically necessary hospital-provided services operating, recovery, and other treatment rooms
• Anesthesia and administration (facility technical component)
• Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero).
• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include but are not limited to:
  ○ dilation and curettage (D&C) procedures,
  ○ appropriate Provider-administered medications, ultrasounds, and
  ○ histological examination of tissue samples.
	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.
	For CHIP Perinates in families with incomes above 198% and up to and including 202% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.
		None

Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Healthcare Center Services include the following services provided in a hospital clinic or emergency	Requires prior authorization and physician prescription. Laboratory and radiological services are limited to services that directly relate to ante	None

Covered Benefits	Limitations	Co-Payments
room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Outpatient services associated with miscarriage or non- viable pregnancy include, but are not limited to: ○ dilation and curettage (D&C) procedures, ○ appropriate Provider-administered medications, ultrasounds, and histological examination of tissue samples.	partum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urine analysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker	

Covered Benefits	Limitations	Co-Payments
	screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.	
Physician/Physician Extender Professional Services include but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals, and materials administered in physician's office • Professional component (in/outpatient) of surgical services, including: ○ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. ○ Administration of anesthesia by physician (other than surgeon) or CRNA ○ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. ○ Surgical services associated with (a) miscarriage or (b) a	Does not require authorization for specialty services for use of contracted Providers. Requires authorization for use of out-of-network Providers. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high risk pregnancy, fetal growth retardation or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.	None

Covered Benefits	Limitations	Co-Payments
non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Hospital-based physician services (including physician-performed technical and interpretive components). Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to, dilation and curettage (D&C) procedures, appropriate Provider-administered medications, ultrasounds, and histological examination of tissue samples.		
Prenatal Care and Pre-Pregnancy Family Services and Supplies Covered services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	Does not require authorization for specialty services for use of contracted Providers. Requires authorization for use of out-of-network Providers. Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose	None

Covered Benefits	Limitations	Co-Payments
	every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin ad-ministration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	
Emergency Services, Including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Medical conditions or Emergency Behavioral Health conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.	None

Covered Benefits	Limitations	Co-Payments
Case Management Services Case management services are a covered benefit for the unborn child.	These covered services include outreach informing, case management, care coordination, and community referral.	None
Care Coordination Services Care coordination services are a covered benefit for the unborn child.		None

Value-Added Services

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

CHIP Perinatal Newborn

- 24-Hour Advice Hotline

  Nurse Help Line for all Members 24 hours per day to help Members decide where to go to get the care needed. The nurses also provide health education, nurse-initiated follow-up, and network referrals.
- Transportation Services

  Help with getting a ride to a doctor's visit
- Disease Management

  Educational materials for Members who are enrolled in our Asthma and Diabetes Care Management Programs

CHIP Perinatal Unborn

- 24-Hour Advice Hotline

  Nurse Help Line for all Members 24 hours per day to help Members decide where to go to get the care needed. The nurses also provide health education, nurse-initiated follow-up, and network referrals.
- Transportation Services

  Help with getting a ride to a doctor's visit
- Disease Management

  Educational materials for Members who are enrolled in our Asthma and Diabetes Care Management Programs

CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinates

- For CHIP Perinates in families with incomes at or below 198% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy and postpartum care related to the covered unborn child until birth
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based healthcare services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the delivery of the covered unborn child
- Transplant services
- Tobacco Cessation Programs
- Chiropractic services
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or postpartum care
- Experimental and/or investigational medical, surgical or other healthcare procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court

- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
- Mechanical organ replacement devices including but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care related to the labor and delivery of the covered unborn child
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes)
- Diagnosis and treatment of weak, strained or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self- administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy or vision services
- Reimbursement for school-based physical therapy, occupational therapy or speech

therapy services are not covered

- Donor non-medical expenses
- Charges incurred as a donor of an organ

Behavioral Health

Expectant mothers enrolled in CHIP Perinatal are not entitled to behavioral health services. Please refer to the CHIP portion of this manual for information on behavioral health benefits for CHIP Perinatal newborns.

CHIP Perinatal Program Covered Services for CHIP Perinate Newborns 198% to 202% FPL

Covered Benefits	Limitations	Co-Payments
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Include: • Hospital-provided physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free- of-charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy	• Requires authorization for non- emergency • Care and care following stabilization of an emergency condition. • Requires authorization for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by Cesarean section.	None
• Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an un-complicated delivery by Cesarean section.		

Covered Benefits	Limitations	Co-Payments

• Hospital, physician and related medical services such as anesthesia associated with dental care.
• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include but are not limited to:
  ○ dilation and curettage (D&C) procedures;
  ○ appropriate Provider-administered medications;
  ○ ultrasounds; and
  ○ histological examination of tissue samples.
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  ○ cleft lip and/or palate; or
  ○ severe traumatic, skeletal, and/or congenital craniofacial deviations; or
  ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
• Surgical implants
• Other artificial aids, including surgical implants
• Inpatient services for a mastectomy and breast reconstruction include:
  ○ all stages of reconstruction on the affected breast;
  ○ surgery and reconstruction on the other breast to produce symmetrical appearance; and
  ○ treatment of physical complications from the mastectomy and treatment of lymphedemas.		

Covered Benefits	Limitations	Co-Payments
• Implantable devices are covered under inpatient and outpatient services and do not count toward the DME 12-month period limit		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include but are not limited to the following: • Semi-private room and board • Regular nursing services • Rehabilitation services Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and physician prescription. • 60 days per 12-month period limit	None
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Healthcare Center Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia associated with dental care	May require prior authorization, as indicated below, and physician prescription. • X-ray, imaging, and radiological tests (technical component)-may require prior authorization • Laboratory and pathology services (technical component)-may require prior authorization • Machine diagnostic tests • Ambulatory surgical facility services-may require prior authorization • Drugs, medications and biologicals-may require prior authorization • Casts, splints, dressings-may require prior authorization • Preventive health services-does not require prior authorization • Physical, occupational, and speech therapy - requires prior authorization • Renal dialysis-does not require prior authorization	None for preventive service

Covered Benefits	Limitations	Co-Payments
when provided in a licensed ambulatory surgical facility. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ○ dilation and curettage (D&C) procedures; ○ appropriate Provider-administered medications; ○ ultrasounds; and ○ histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip and/or palate or severe traumatic, skeletal ○ and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment.	• Respiratory services-may require prior authorization • Radiation and chemotherapy-may require prior authorization • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products-does not require prior authorization • Facility and related medical services such as anesthesia associated with dental care when provided in a licensed ambulatory surgical facility-requires prior authorization. • May require prior authorization for nonemergency services • Does not require PCP referral • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	
• Surgical implants • Other artificial aids, including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory healthcare center for a mastectomy and	• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Outpatient	

Covered Benefits	Limitations	Co-Payments
breast reconstruction as clinically appropriate, include: ○ all stages of reconstruction on the affected breast; ○ surgery and reconstruction on the other breast to produce symmetrical appearance; and ○ treatment of physical complications from the mastectomy and treatment of lymphedemas. Implantable devices are covered under inpatient and outpatient services and do not count toward the DME 12-month period limit	services associated with miscarriage or nonviable pregnancy include but are not limited to: ○ dilation and curettage (D&C) procedures; ○ appropriate Provider-administered medications; ○ ultrasounds; and ○ histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat; may require prior authorization ○ cleft lip and/or palate; or ○ severe traumatic, skeletal and/or congenital craniofacial deviations; or ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment • Surgical implants-may require prior authorization • Other artificial aids including surgical implants-may require prior authorization	

Covered Benefits	Limitations	Co-Payments
	• Outpatient services provided at an outpatient hospital and ambulatory healthcare center for a mastectomy and breast reconstruction as clinically appropriate, include but do not require prior authorization: ○ all stages of reconstruction on the affected breast; ○ surgery and reconstruction on the other breast to produce symmetrical appearance; and • treatment of physical complications from the mastectomy and treatment of lymphedemas	
Physician/Physician Extender Professional Services include, but are not Limited to the Following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient and outpatient services • Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including:	Requires prior authorization for specialty services as indicated below: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) – Does not require prior authorization • Physician office visits, in-patient and outpatient services – Does not require prior authorization • Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation – Does not require prior authorization	

Covered Benefits	Limitations	Co-Payments
- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a hospital without an overnight stay - Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section.	• Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections – May require prior authorization • Professional component (in/outpatient) of surgical services, including the following – May require prior authorization: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a hospital without an overnight stay - Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components) – Does not require prior authorization • Physician and professional services for a mastectomy and breast reconstruction include but do not require prior authorization: • all stages of reconstruction on the affected breast;	
Physician services medically necessary to support a dentist providing dental services to a	- surgery and reconstruction on the other breast to	

Covered Benefits	Limitations	Co-Payments
CHIP Member such as general anesthesia or intravenous (IV) sedation. Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include but are not limited to: - dilation and curettage (D&C) procedures; - appropriate Provider-administered medications; - ultrasounds; and - histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section – in network does not require prior authorization; out-of-network requires prior authorization • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation – requires prior authorization • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) may require prior authorization. Physician services associated with miscarriage or non-viable pregnancy include but are not limited to (does not require prior authorization): - dilation and curettage (D&C) procedures; - appropriate Provider-administered medications; - ultrasounds; and	

Covered Benefits	Limitations	Co-Payments
	- histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat (requires prior authorization): - cleft lip and/or palate; or severe traumatic, skeletal, and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of Illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses	• May require prior authorization and physician prescription. - $20,000 per 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (implantable devices, diabetic supplies, and equipment are not counted against this cap).	None

Covered Benefits	Limitations	Co-Payments
• Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count toward the DME 12-month period limit. Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.		
Home and Community Health Services Services that are provided in the home and community, including but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. Speech, physical, and occupational therapies.	• Requires prior authorization and physician prescription. • Services are not intended to replace the child's caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. - Services are not intended to replace 24- hour inpatient or skilled nursing facility services	None
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities, including but not limited to: • Neuropsychological and psychological testing	Requires prior authorization for non-emergency services. Does not require PCP referral. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding	None

Covered Benefits	Limitations	Co-Payments
	determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • • May require prior authorization.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to: • The visits can be furnished in a variety of community- based settings (including school and home-based) or in a state-operated facility. • Neuropsychological and psychological testing. • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) Skills training (psycho-educational skill development)	• Does not require PCP referral. • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • A Qualified Mental Health Provider–Community Services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title 25 • T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be Providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHPCSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those	

Covered Benefits	Limitations	Co-Payments
	services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient Substance Abuse Treatment Services Inpatient substance abuse treatment services include but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.	• Requires prior authorization for non- emergency services. • Does not require PCP referral.	None
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include but are not limited to the following: • Prevention and intervention services that are provided by physician and non-physician Providers such as screening, assessment, and referral for chemical dependency disorders. • Intense outpatient services • Partial hospitalization • Intensive outpatient services are defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks but less than 24 hours per day. Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.	• Requires prior authorization. • Does not require PCP referral.	None
Rehabilitation Services	• • Requires prior authorization and physician prescription	None

Covered Benefits	Limitations	Co-Payments
Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include but are not limited to the following: • Physical, occupational, and speech therapy Developmental assessment		
Hospice Care Services Services include but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	• Requires authorization and physician prescription • Services apply to the hospice diagnosis • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at any time	None
Emergency Services, Including Emergency Hospitals, Physicians, and Ambulance Services Health plan cannot require authorization as a condition for payment for emergency medical or emergency behavioral health conditions or labor and delivery. Covered services include: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network Providers • Medical screening examination • Stabilization services • Access to DSHS-designated Level 1 and Level II trauma centers or hospitals meeting	• Requires authorization for post-stabilization services.	None

Covered Benefits	Limitations	Co-Payments
equivalent levels of care for emergency services • Emergency ground, air, and water transportation Emergency dental services limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts		
Transplants Covered services include using up-to-date FDA guidelines, all nonexperimental human organ and tissue transplants, and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses.	• Requires authorization	None
Vision Benefit Covered services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period The health plan may reasonably limit the cost of the frames/lenses.	• May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye	None
Tobacco Cessation Program Covered up to $100 for a 12-month period limit for a plan-approved program • May require authorization Health plan defines plan-approved program.	• May be subject to formulary requirements	None

Note: Spell of Illness Limitation Removed for CHIP Perinate Newborns

CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinate Newborns

With the exception of the first bullet, all of the following exclusions match those found in the CHIP Program.

- For CHIP Perinate Newborns in families with incomes at or below 198% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial perinatal newborn admission. “Initial perinate newborn admission” means the hospitalization associated with birth.
- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other healthcare procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including but not limited to those for schools, employment, flight clearance, camps, insurance or court
- Private-duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices including but not limited to artificial heart
- Hospital services and supplied when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by health plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)

- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver; this care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy or vision services
- Reimbursement for school-based physical therapy, occupational therapy or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.

CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when medically necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

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

Coordination with Non-CHIP Covered Services (non-capitated services)

Community Health Choice is not responsible for providing the services listed below but is responsible for appropriate referrals for these services. We will enlist the involvement of community organizations that may not provide CHIP-covered services but are otherwise important to the health and well-being of Members. We will make a best effort to establish relationships with these community organizations to make referrals. CHIP Members who meet the criteria for children with complex special healthcare needs (CSHCN) have access to community organizations for assistance with referrals and services for their complex healthcare needs. These organizations may include:

- Texas agency-administered programs and case management services
- Essential public health services

Our case managers can offer assistance with coordination of care for these Members.

CHIP Perinatal Complaints and Appeals

CHIP Perinatal Provider Complaints Process

"CHIP or CHIP Perinatal Complaint" is defined as any dissatisfaction, expressed by a complainant, orally or in writing to Community Health Choice, with any aspect of Community Health Choice's operation, including but not limited to dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member. A Provider may file a complaint at any time with Community Health Choice. Send complaints to:

Community Health Choice
Attn: Service Improvement
4888 Loop Cen tral Dr.
Houston, TX 77081

Fax: 713.295.7036
Email: ServiceImprovement@CommunityHealthChoice.org

Complaints may also be submitted online at the Community Health Choice website CommunityHealthChoice.org.
Community Health Choice shall acknowledge all written complaints within five business days. If a Provider's complaint is oral, Community Health Choice's Acknowledgement Letter shall include a one-page Complaint Form.

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

Documentation

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

Provider Appeals Process

Key Terms to Understand

"Appeal" means the formal process by which Community Health Choice addresses adverse determinations.

“Adverse Determination” is a decision by Community Health Choice that is a service furnished to a Member, or proposed to be furnished to a Member, that is not medically necessary, experimental/investigational or appropriate.

Appeal of an Adverse Determination

A Provider may request an appeal of an Adverse Determination orally or in writing within 30 calendar days of the date on Community Health Choice’s written notification of an Adverse Determination. Provider appeals must be in writing and accompanied by complete medical records. You may request your appeal verbally or in writing:

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

Phone: 713.295.2294
Toll Free: 1.888.760.2600
Fax: 713.576.7033

If the appeal request was made orally, the acknowledgement letter will also include a one-page appeal form to be filled out by the appealing Provider.

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

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

(a) a statement of the specific medical, dental, or contractual reasons for the resolution;
(b) the clinical basis for the decision;
(c) a description of or the source of the screening criteria that were utilized in making the determination;
(d) the professional specialty of the physician who made the determination;
(e) procedures for filing a complaint.

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

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

Expedited Appeals Procedures for Medical Necessity

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

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

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

You also have the right to file a complaint about this process. To file a complaint, please contact Community Health Choice at:

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

Phone: 713.295.2294
Toll Free: 1.888.760.2600
Fax: 713.295.7036

Community Health Choice must resolve your complaint within thirty (30) days.

Documentation

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

Independent Review Organization (IRO)

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

Community Health Choice
Attn: Medical Affairs –Appeals
4888 Loop Central Dr.
Houston, TX 77081

Phone: 713.295.2294
Toll Free: 1.888.760.2600
Fax: 713.295.7033

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

When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through Community Health Choice's complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 149091, Austin, Texas 78714- 9091. Complaints to the Texas Department of Insurance may also be filed electronically at TDI.state.tx.us.

CHIP Perinatal Member Complaints and Appeals

CHIP Perinatal Member Complaints Process How to file a complaint

Members, or their authorized representatives, may file an oral or written complaint with Community Health Choice. Members may make complaints to Community Health Choice in writing, sent to the following address:

Community Health Choice
Service Improvement
4888 Loop Central Dr.
Houston, TX 77081

Or by calling Community Health Choice toll free at 1.888.760.2600.

Members should provide as much detail as possible describing their complaint. If Providers are involved, the name(s) of each Provider and, if services are involved, a description of the services and the date(s) of service. If the complaint is given orally, Community Health Choice will mail a one- page Complaint Form to the Member. The Member should complete and return the Complaint Form to Community Health Choice as soon as possible for prompt resolution.

Can someone from Community Health Choice help my Member file a complaint?

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

Requirements and Time Frames for Filing a Complaint

Community Health Choice will, no later than the fifth business day after the date of the receipt of the complaint, send to the Member a letter acknowledging the date the complaint was received. If the complaint was received orally, Community Health Choice will include a one-page Complaint Form stating that the Complaint Form should be returned to Community Health Choice for prompt resolution.

After Community Health Choice receives the complaint, Community Health Choice will investigate and send Member a Resolution Letter. The total time for acknowledging, investigating, and resolving Member complaints will not exceed 30 calendar days after the date Community Health Choice receives the Member complaint.

Member complaints concerning an emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of the Member complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Members may use the complaint appeals process to resolve a dispute regarding the resolution of a Member complaint.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through Community Health Choice's complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 149091, Austin, Texas 78714- 9091. Complaints to the Texas Department of Insurance may also be filed electronically at TDI.state.tx.us.

Member Appeals Process

If the Member complaint is not resolved to the Member's satisfaction, the Member has the right either to appear in person before a Complaint Appeal Panel where the Member normally receives healthcare services, unless another site is agreed to by the Member, or to address a written appeal to the Complaint Appeal Panel. Community Health Choice will complete the appeals process no later than the thirtieth (30th) calendar day after the date of the receipt of the request for complaint appeal.

Community Health Choice
Service Improvement
4888 Loop Central Dr.
Houston, TX 77081

713.295.2294 or 1.888.760.2600; TDD 7-1-1

Community Health Choice will send an Acknowledgment Letter to Member not later than the fifth day after the date of receipt of the request of the complaint appeal.

Community Health Choice will appoint Members to the Complaint Appeal Panel, which will advise Community Health Choice on the resolution of the dispute. The Complaint Appeal Panel will be composed of an equal number of Community Health Choice staff, physicians or other Providers, and enrollees. A member of the Complaint Appeal Panel may not have been previously involved in the disputed decision.

Not later than the fifth business day before the scheduled meeting of the Complaint Appeal Panel, unless Member agrees otherwise, Community Health Choice will provide to Member or Member's designated representative:

- any documentation to be presented to the panel by Community Health Choice's staff;
- the specialization of any physicians or Providers consulted during the investigation; and
- the name and affiliation of each of Community Health Choice's representatives on the panel. Member, or Member's designated representative if Member is a minor or disabled, are entitled to:

1. appear in person before the Complaint Appeal Panel;
2. present alternative expert testimony; and

3. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case, but in no event to exceed one business day after Member's request for appeal.

Due to the ongoing emergency or continued hospital stay, and at Member's request, Community Health Choice will provide, in lieu of a Complaint Appeal Panel, a review by a physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal.

Notice of our final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

What can I do if Community Health Choice denies or limits my Member's request for a Covered Service?

A Member has the right to appeal any services that have been denied by Community Health Choice that do not meet the criteria of medical necessity. A denial of this type is called an "Adverse Determination."

An Appeal is considered a disagreement with an Adverse Determination. A Member can request an appeal orally or in writing.

How to File an Appeal

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

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

Fax: 713.295.7033

If a Member files a written appeal, Community Health Choice will send the requestor a written acknowledgement within five business days.

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

Members, or their representatives, should provide as much detail as possible describing their appeal. If Providers are involved, the name(s) of each Provider and if services are involved, a description of the services and the date(s) of service. Members must understand that if the appeal

decision is adverse to the Member, the Member may be financially responsible for the services which were the subject of the appeal, including services furnished while the appeal is pending.

Time Frame for Filing an Appeal

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

Time Frame for Resolution of an Appeal

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

Can someone from Community Health Choice help me file an appeal?

If a Member needs assistance filing an appeal, they may call Community Health Choice Member Services at 713.295.2294 or 1.888.760.2600 and an appeals coordinator will assist them with the appeal.

Expedited Member MCO Appeal Right to an Expedited Appeal

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

How to File an Expedited Appeal

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

Community Health Choice
Appeals Department
4888 Loop Central Dr.
Houston, TX 77081

Phone: 713.295.2295 or 1.888.760.2600
Fax: 713.295.7033

Community Health Choice will accept expedited appeals 24 hours a day, seven days a week. Requests for expedited appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal. An acknowledgement of the expedited appeal will be communicated to the requestor on the next business day.

Resolution Time Frame for an Expedited Appeal

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

1. in accordance with the medical immediacy of the case; and
2. not later than one business day after Community Health Choice receives the request for the expedited appeal.

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

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

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

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

If Community Health Choice determines that a Member's appeal request does not follow the definition of expedited appeal, it will treat the appeal as a standard appeal. Community Health Choice shall make a reasonable effort to notify the requestor that the appeal is being treated as a standard appeal, with written notice being provided within two calendar days.

Who can help me file an Expedited Appeal?

For assistance with an appeal or expedited appeal, call Member Services toll free 1.888.760.2600.

External Review by Independent Review Organization

An Independent Review Organization (IRO) makes decisions on medical necessity and appropriateness of care. If the appeal of the Adverse Determination is denied, a Member, Member's designated representative or Member's physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When Community Health Choice or Community Health Choice's Utilization Review Agent deny the appeal, the Member, Member's designated representative or Member's physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a life-threatening condition, Member is entitled to an immediate

review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In life-threatening situations, Member, Member's designated representative or Member's physician or Provider of record may contact Community Health Choice or Community Health Choice's Utilization Review Agent by telephone to request the review by the IRO and Community Health Choice or Community Health Choice's Utilization Review Agent will provide the required information. Members may call Member Services and ask for an "Independent Review Organization Form" at 713.285.2294 or 1.888.760.2600.

When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

Community Health Choice will immediately notify the IRO's managing entity of the request for IRO review. The IRO's managing entity will assign the case to an IRO within one business day. If the IRO requests any information, Community Health Choice must provide the information to the IRO's managing entity within three (3) business days. The IRO must reach a decision within 15 days, but no later than 20 days after the IRO receives the case from the IRO's managing entity. In cases involving life-threatening conditions, the IRO must reach a decision within five (5) days, but no later than eight (8) days after the IRO receives the case from the IRO's managing entity.

When the IRO completes its review and issues its decision, Community Health Choice will abide by the IRO's decision. Community Health Choice will pay for the IRO review.

An IRO review is not available if Community Health Choice denies payment for a non-covered service, such as cosmetic surgery. IRO review is also not available if a Member has already received treatment and Community Health Choice determined that the treatment was not medically necessary.

The appeal procedures described above do not prohibit a Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if a Member believes that the requirement of completing the appeal and review process places the Member's health in serious jeopardy.

CHIP Perinatal Member Eligibility

Eligibility

An expectant mother enrolled in CHIP Perinatal receives limited prenatal care benefits and her coverage ends at the time of birth. Her unborn child receives 12 months of continuous coverage, starting on the effective date.

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

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

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

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

Eligibility for CHIP and CHIP Perinatal enrollment is determined by the Administrative Services Coordinator.

Verifying Eligibility

All Community Health Choice Members are issued a Community Health Choice Member ID Card. When verifying Member eligibility, ask for your patient's Community Health Choice CHIP Member ID Card. Make a copy of both sides of the card for the Member's file. Before providing services, verify that you have received an authorization number for inpatient or outpatient services. Failure to obtain authorization may result in a denial by Community Health Choice. To verify Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community Health Choice Online at CommunityHealthChoice.org. You will need to fill out the Community Health Choice Secure Access Application to become an authorized user. Call Community Health Choice Member Services to get more information.
- Community Health Choice Member Services at 713.295.2294 or 1.888.760.2600. You can check eligibility and benefits. Expectant mothers enrolled in CHIP Perinatal will not be assigned a PCP.
- Providers can receive eligibility information by calling the CHIP/CHIP Perinatal Provider eligibility hotline Monday through Friday 8:00 a.m. to 5:00 p.m. (Central Time). The hotline number is 1.800.647.6558. Providers who call the hotline can speak with a customer service representative to confirm whether an expectant mother or newborn child is a currently enrolled CHIP Perinatal

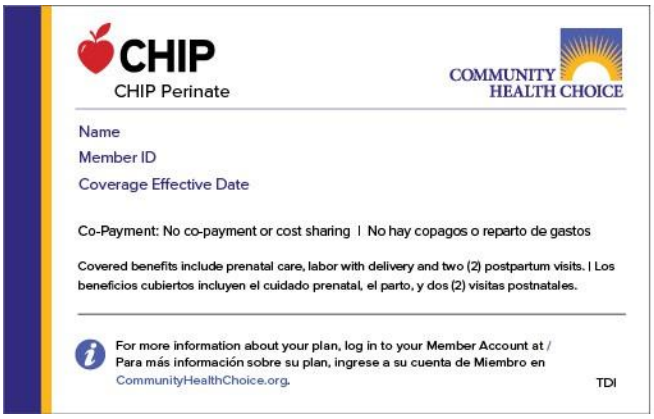
Member or receive an automated response if the Provider has a CHIP Perinatal Member ID number

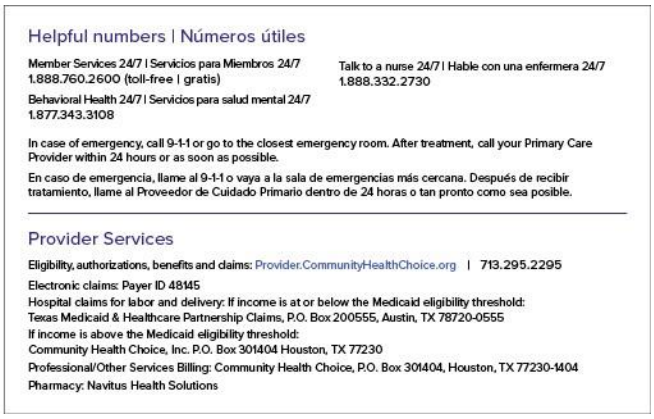
Be sure to have the following information when you call or go to Community Health Choice Online:

- Member's name
- Member's ID number

CHIP Perinatal Member ID

Cards CHIP Perinatal Unborn





CHIP Perinatal Newborn ID Card

Application Assistance

Community Health Choice offers personal assistance to Community Health Choice Members wishing to enroll in Medicaid or CHIP at the end of their CHIP Perinatal enrollment. Keeping benefits going is vital and the application process can be confusing. Community Health Choice offers meetings and personal help at this difficult time.

If your Community Health Choice Member needs assistance with the filing process, please have them call 713.295.2222 or 1.877.635.6736 and Community Health Choice will tell the Member

about meetings or will assist them over the phone. If the Member needs a Renewal Form, they should call the CHIP Help Line at 1.800.647.6558 or call Community Health Choice Member Services to get one.

CHIP Perinate Member Rights and Responsibilities

References to "you" or "your" apply to the mother of the Perinate (Unborn Child)

CHIP Perinate Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other Providers.
2. You have a right to know how the Perinatal Providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal Providers in the health plan and their addresses.
5. You have a right to pick from a list of healthcare Providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other Providers.
10. You have the right to talk to your Perinatal Provider in private and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal Providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member's Right to Designate An OB/GYN

Community Health Choice allows the Member to pick an OB/GYN, but this doctor must be in the same network as the Member's PCP.

ATTENTION FEMALE MEMBERS

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

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

Member Responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care Providers, other Members or health plans.
7. Talk to your Provider about all of your medications.

CHIP Perinatal Member Cost Sharing Schedule

There is no cost sharing or enrollment fee for Members enrolled with CHIP Perinatal.

Billing Members

HHSC rules prohibit Providers from balance billing CHIP Members (See TAC §370.453). Specifically, HHSC rules require Providers of services to CHIP Members to accept payment received for covered services as payment in full, and prohibits Providers from billing the CHIP Member, the CHIP Member's family or the CHIP Member's their guardians for any remaining balances for covered services rendered. HHSC balance billing rules apply to network Providers

and non-network Providers of authorized services.

Providers may only charge CHIP Members the copayment amounts authorized for services that are not covered under CHIP.

Providers are responsible for collecting all CHIP Member co-payments at the time of service.

CHIP Perinatal Member Enrollment and Disenrollment from Community Health Choice

Enrollment

Expectant mothers who enroll in CHIP Perinatal receive up to 12 months of continuous coverage, beginning on the effective date of her eligibility. Eligibility for enrollment in CHIP and Medicaid is determined by the Texas Health and Human Services Commission's Administrative Services Contractor.

CHIP Perinatal Newborn Process

Families must apply for Medicaid or CHIP prior to the end of the 12 months to ensure continuous eligibility. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form that will be pre-populated to include the CHIP Perinate Newborn's and CHIP Member's information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her sibling's existing CHIP case.

Disenrollment

Disenrollment due to loss of CHIP Perinatal Eligibility

Disenrollment may occur if a Member loses CHIP Perinatal eligibility. A CHIP Perinatal Member will lose CHIP Perinatal eligibility for the following reasons:

- Change in health insurance status, i.e., a parent of an UNBORN CHILD enrolls in an employer- sponsored health plan;
- Miscarriage resulting in the termination of the pregnancy;
- Death of the UNBORN CHILD;
- Mother of the UNBORN CHILD permanently moves out of the State;
- Voluntary disenrollment (in writing) is requested by the Perinate mom or acting on behalf of the newborn.

Disenrollment by Community Health Choice

Community Health Choice has a limited right to request a Member be disenrolled from Community Health Choice without the Member's consent. HHSC must approve and Community Health Choice request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Fraud or intentional material misrepresentation made by YOU after 15 days written notice
- Fraud in the use of services or facilities after 15 days written notice
- Misconduct that is detrimental to safe plan operations and the delivery of services
- Mother of the UNBORN CHILD no longer lives or resides in the service area.

- Mother of the UNBORN CHILD is disruptive, unruly, threatening or uncooperative to the extent the UNBORN CHILD's membership seriously impairs Health Plan's or Provider's ability to provide services to the UNBORN CHILD or to obtain new Members, and the mother of the UNBORN CHILD's behavior is not caused by a physical or behavioral health condition.
- Mother of the UNBORN CHILD steadfastly refuses to comply with Health Plan restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Health Plan to treat the underlying medical condition).

Community Health Choice must notify the Member of Community Health Choice's decision to disenroll the Member if all reasonable measures have failed to remedy the situation.

If the Member disagrees with the decision to disenroll the Member from Community Health Choice, then Community Health Choice must notify the Member of the availability of the complaints procedure.

Community Health Choice cannot request a disenrollment based on adverse change in the Member's health status or utilization of services that are medically necessary for treatment of a Member's condition.

Community Health Choice will not disenroll a Member based on a change in the Member's health status or because of the amount of medically necessary services that are used to treat the Member's condition.

HHSC will make the final decision regarding disenrollment of a Member from Community Health Choice.

Providers may not take retaliatory action against Members.

Plan Changes

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

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

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

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a Member of a household enrolls in CHIP Perinatal, all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if the plan is different. All Members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal Member's enrollment period or (2) the end of the traditional CHIP Members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

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

- for any reason within 90 days of enrollment in CHIP Perinatal
- if the Member moves into a different service delivery area; and
- for cause at any time.

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

Key Information for Long-Term Services and Supports Providers

As a reminder, the following are tips to providing LTSS services:

- Verify member eligibility with Community Health Choice before performing services.
- Ensure necessary referral/authorizations have been obtained from Community Health Choice prior to provision of services.
- Use the NPI and taxonomy code when filing claims for LTSS services.
- Bill and report LTSS services in compliance with the HHS Billing Matrix for LTSS HCPC codes and STAR+PLUS Modifiers Matrix.
- Notify the member's service coordinator whenever there is a change in the member's physical or mental condition, upon knowledge of an inpatient or nursing facility admissions, all member complaints or grievances, or if you identify a member needs services outside the Community Health Choice contracted scope of services with the provider.
- Ensure for members who are eligible for both Medicare and Medicaid that covered Medicare services are billed

to Medicare as primary prior to accessing services under Medicaid or HCBS STAR+PLUS (c) waiver services.

- Refer to the LTSS bulletin(s) posted on the Texas Medicaid Health care Partnership (TMHP) website at

www.tmhp.com for additional information

STAR+PLUS Member Eligibility

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

assist Medicaid recipients with chronic and complex conditions who require more than acute care services.

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

Mandatory Members

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

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

Voluntary Members

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

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

Excluded Individuals

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

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

• Individuals receiving long-term care services through non-Medicaid funded programs

Texas Benefits Medicaid Card

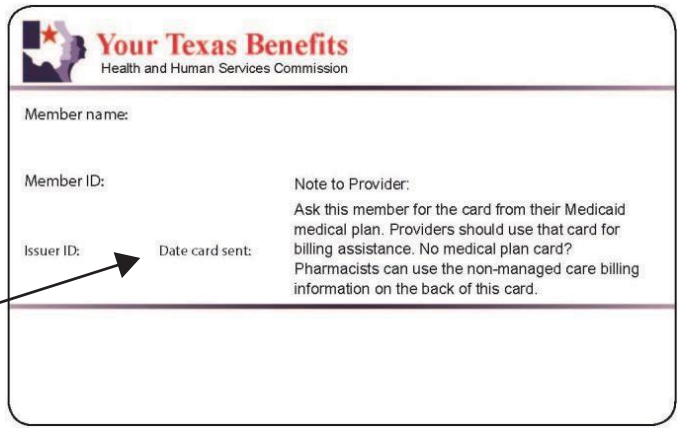
Front of the Card

This is where your name appears

This is where Medicaid ID Number

This is HHSC's Agency ID number. Doctors and other providers need this number

This is the date the card was sent to you

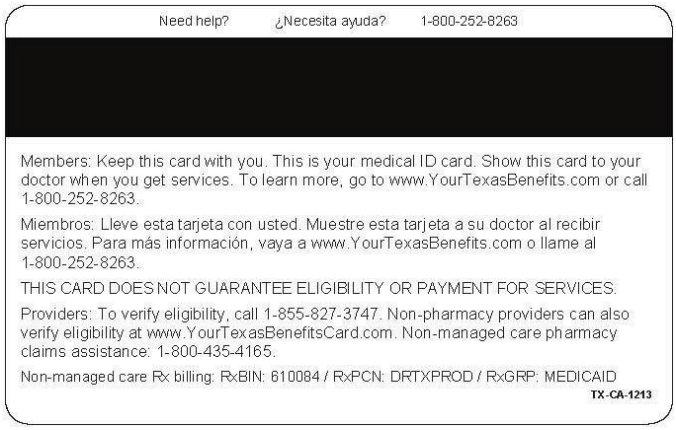


Back of the card:

This message is for you.

This reminds your doctor to make sure you are still in the Medicaid program before giving you services.

These messages help doctors and providers get paid for the Medicaid services they give you



Verifying Community Health Choice Member Eligibility

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

When verifying Member eligibility, ask for your patient's Community Health Choice Member ID Card and their Your Texas Benefit Medicaid Card. Make a copy of both sides of the card for the Member's file. Before providing services, verify that you have received an authorization number for inpatient or selected outpatient services. Failure to obtain authorization may result in a denial

by Community Health Choice. To verify Community Health Choice Member eligibility, you can access one of the following sources 24 hours a day, seven days a week:

- Community Health Choice Online at CommunityHealthChoice.org. Complete the Community Health Choice Secure Access Application to become an authorized user.
- Call Community Health Choice Member Services to get more information.
- Community Health Choice Provider Services at 713.295. 2300 or 1.888.435.2850 . You can check eligibility, benefits and PCP selection.
- Providers may also contact the TMHP Automated Inquiry System (AIS) at 1.800.925.9126 and by visiting TexMedConnect Provider portal on the TMHP website at TMHP.com.
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only) Be sure to have the following information when you call or go to Community Health Choice Online:
    - Member's name
    - Member's ID number
    - Member's designated PCP

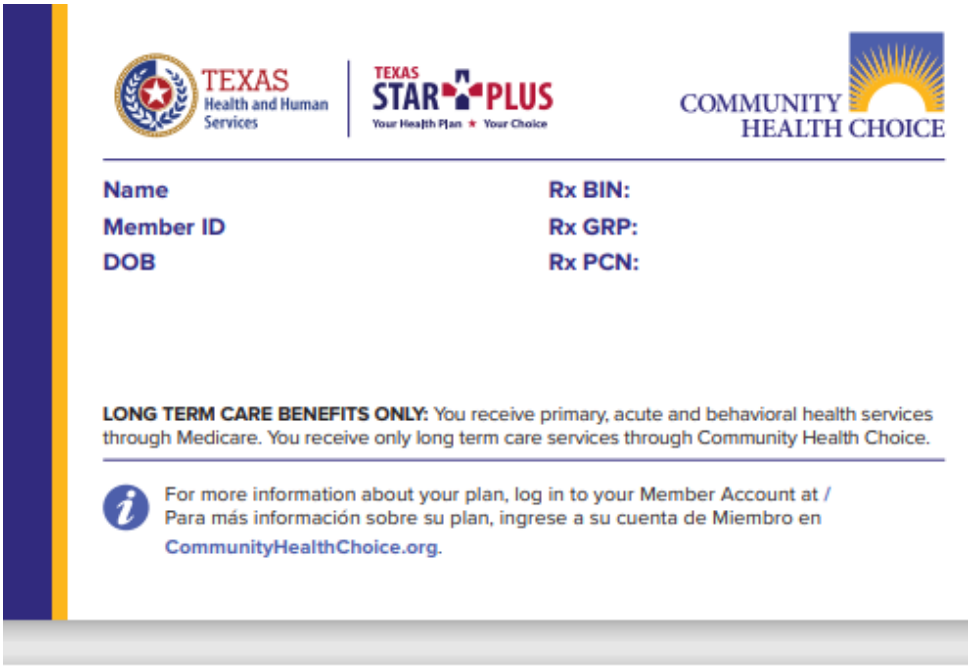
Community Health Choice Member ID Card

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

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

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

CHC STAR+PLUS DUAL ID CARD



TEXAS Health and Human Services | TEXAS STAR+PLUS Your Health Plan ★ Your Choice | COMMUNITY HEALTH CHOICE

Name
Member ID
DOB

Rx BIN:
Rx GRP:
Rx PCN:

LONG TERM CARE BENEFITS ONLY: You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through Community Health Choice.

For more information about your plan, log in to your Member Account at / Para más información sobre su plan, ingrese a su cuenta de Miembro en CommunityHealthChoice.org.

Helpful numbers | Números útiles

Member Services 24/7 | Servicios para Miembros 24/7
1.888.435.2850 TTY 711 (toll-free | gratis)

Talk to a nurse 24/7 | Hable con una enfermera 24/7
1.800.206.9052 TTY 711

Service Coordination 24/7 | Coordinación de Servicio 24/7
1.888.435.5150 TTY 711, 713.295.5004 TTY 711

Behavioral Health 24/7 | Servicios para salud mental 24/7
1.877.343.3108 TTY 711

In case of emergency, call 9-1-1 or go to the closest emergency room. After treatment, call your Primary Care Provider within 24 hours or as soon as possible.

En caso de emergencia, llame al 9-1-1 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al Proveedor de Cuidado Primario dentro de 24 horas o tan pronto como sea posible.

Provider Services

Eligibility, authorizations, benefits and claims:
Provider.CommunityHealthChoice.org | 713.295.2300 TTY 711

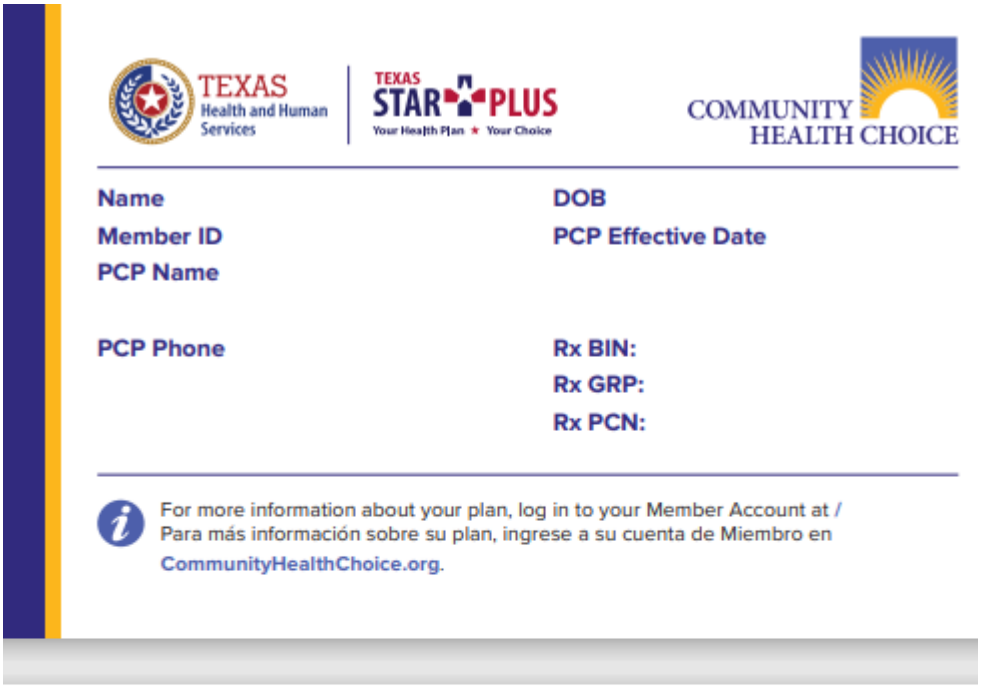
Send claims to: Community Health Choice, P.O. Box 301404, Houston, TX 77230

Electronic claims: Payer ID 48145

Pharmacy: Navitus Health Solutions
1.877.908.6023 TTY 711 **BIN: 610602** **PCN: NVTD** **RXGroup: CHCD002**

cd_revised_STAR+PLUS

CHC STAR+PLUS NON-DUAL ID CARD



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Pharmacy: Navitus Health Solutions
1.877.908.6023 TTY 711 **BIN: 610602** **PCN: MCD** **RXGroup: CHC**

Complaints & Appeals

STAR+PLUS Member Complaint Process How to File a Complaint

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

Community Health Choice
Service Improvement
4888 Loop Central Dr Houston, TX 77081

Or by calling Community Health Choice toll free at 1.888.760.2600.

Once a Member has gone through the Community Health Choice Complaint process, the Member can complain to HHSC, by calling toll free at 1.866.566.8989 or in writing, emailed to HPM_Complaints@hhs.texas.gov or mailed to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247
If you can get on the Internet, you can submit your complaint at: hhs.texas.gov/managed-care-help

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

Requirements and Time Frames for Filing a Complaint

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

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

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

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

What can I do if Community Health Choice denies or limits my Member's request for a Covered Service?

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

Member Appeal Process How to File an Appeal

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

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

Phone 713.295.2300 or 1.888.435.2850
Fax: 713.295.7033

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

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

If the Member disagrees with the denial of the service and/or the payment of those services, the Member may file an appeal using the information detailed in this chapter.Members, or their

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

Time Frame for Filing an Appeal

Members must file a request for appeal within 60 calendar days from receipt of a Notice of an Action. To ensure continuation of currently authorized services, a Member must file an appeal on or before the later of: (1) 10 calendar days following Community Health Choice's mailing and notice of the action or (2) the intended effective date of the proposed action. The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

Time Frame for Resolution of an Appeal

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

How will I find out if services are denied?

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

When can a Member request a State Fair Hearing?

Members must go through the appeal process before requesting a State Fair Hearing. See "State Fair Hearing Information."

Expedited Member MCO Appeal Right to an Expedited Appeal

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

How to File an Expedited Appeal

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

Community Health Choice
Appeals Department
4888 Loop Central Dr
Houston, TX 77081
Phone:
Phone: 713.295.2300 or 1.888.435.2850
Fax: 713.295.7033

Community Health Choice will accept Expedited Appeals 24 hours a day, seven days a week. Requests for Expedited Appeals after hours, on weekends or holidays should be made by calling 713.295.2295 or 1.888.760.2600. Members, or their representatives, should provide information supporting their request for an expedited appeal. An acknowledgement of the expedited appeal will be communicated to the requestor on the next business day.

Resolution Time Frame for an Expedited Appeal

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

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

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

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

3.) the Member requests an extension; or

4.) Community Health Choice advises the Member of a need for additional information and that extending the time frame may be in the Member's best interest.

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

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

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

External Medical Review Information

Can a Member ask for an External Medical Review?

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

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

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.
The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.
Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing the Member can also request the Independent Review Organization to be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at 713-295.2300 or toll- free at 1.888.435.2850 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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

Can a Member ask for an emergency External Medical Review?

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

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

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

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

Or call Toll Free at 1.888.435.2850

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

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by

telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

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

STAR+PLUS LONG-TERM SERVICES ANDS SUPPORTS BENEFIT DESCRIPTION

The following is a description of the long-term services and supports that, depending on the Member's level of need, are offered to Members through regular STAR PLUS services, or through the Home and Community Based Services STAR+PLUS Waiver (SPW) or the Community First Choice (CFC). All of these LTSS services must be preauthorized and coverage of these services is limited to members who need assistance with the activities of daily living. Some services are limited to members who meet the nursing home level of care.

Adaptive Aids and Medical Supplies

Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.

Adult Foster Care

Adult Foster Care (AFC) is a benefit for HCBS STAR+PLUS Waiver (SPW) members that provides a 24-hour living arrangement in an HHSC-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing tasks, supervision, companion services, daily living assistance and provision of, or arrangement for, transportation. 86 The SPW AFC member must reside in an SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. Providers may serve up to three adult members in a HHSC-enrolled AFC home without licensure as a personal care home. Up to four residents may be served in a foster home, though there are limitations as to the number of members at each level who may reside in one home. SPW members are required to pay for their own room and board costs and contribute to the cost of their care, if able, through a copay to the AFC provider.

Assisted Living Facility (ALF)

Provides 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own home. Services are provided in personal care facilities licensed by HHS. Participants are responsible for their room and board costs and, if applicable, copayments for ALF services.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy is available to SPW members to assist a member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the member to compensate for the lost cognitive functions.
Cognitive rehabilitation therapy may be provided when an appropriate professional assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor and includes reinforcing, strengthening, or re-establishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

Day Activity and Health Services (DAHS)

All STAR+PLUS members may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided at facilities licensed or certified by HHSC.

Emergency Response Services (ERS)

Provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven days a week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from the individual.

Financial Management Services

Financial Management Services (FMS) are a benefit available to STAR+PLUS waiver members. Certified Financial Management Services Agencies (FMSA) provide assistance to members to manage funds associated with services elected for self-direction and is provided by a Consumer-Directed Service option. The FMSA must meets necessary qualifications to provide financial management services, including completing the mandatory FMSA enrollment training provided by HHS and meeting eligibility requirements for an HHSC FMSA contract. Examples of FMS include, but are not limited to:

- Providing required initial orientation, ongoing training, assistance and support for employer-related responsibilities;
- Verifying qualifications of applicants before services are delivered and monitoring continued eligibility of service
- providers;
- Approving and monitoring budgets for services delivered through the CDS option;
- Managing payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies (FMSAs are not allowed to use a payroll agent);

- Complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings and benefits;
- Preparing and filing required tax forms and reports;
- Paying allowable expenses incurred by the employer;
- Providing status reports concerning the individual's budget, expenditures and compliance with CDS option requirements;
- Responding to the employer or designated representative as soon as possible, but at least within two Business Days after receipt of information requiring a response from the CDS Agency

Home and Community Based Services (HCBS) STAR+PLUS Waiver Services
The Home and Community-Based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Home Delivered Meals

Meals services provide hot, nutritious meals delivered to an individual's home. The benefit limitation is one meal per Day, and the need for a home delivered meal must be part of the individual service plan. Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food. Home Delivered Meal Providers must report any member illnesses, potential threats to the member's safety or observable changes in the member's condition to the MCO, orally within one Business Day and in writing within five Business Days.

In-Home Skilled Nursing Care

Direct delivery of skilled tasks/procedures by a registered or practical nurse based on an assessment of the member's health care needs, guidance by professional practice standards and physician order if required. Texas Board of Nurse Examiners allows delegation of nursing tasks to unlicensed persons following the development of a care plan and education on proper health maintenance.

Mental Health Rehabilitative Services

Services are defined as age-appropriate services determined by HHS and federally approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness

for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the member to their best possible functioning level in the community.

Mental Health Targeted Case Management

Assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.

Minor Home Modifications

Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home.

Personal Assistance Services (PAS)

Primary home care/personal assistance services (PAS) are available to all STAR+PLUS members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to:

- Assisting with the activities of daily living such as feeding, preparing meals, transferring and toileting.
- Assisting with personal maintenance such as grooming, bathing, dressing, and routine care of hair and skin.
- Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary and safe environment such as changing bed linens, housecleaning, laundering, shopping, storing purchased items and washing dishes.
- Providing protective supervision.
- Providing extension of therapy services.
- Providing ambulation and exercise.
- Assisting with medications that are normally self-administered.
- Performing nursing tasks delegated by registered nurses.
- Escorting the member on trips to obtain medical diagnoses, treatment, or both.

Personal Attendant Services (PAS) Documentation Requirements

Provider agencies providing PAS for Community Health Choice STAR+PLUS members are responsible for maintaining service delivery records. The provider agency must maintain records of the services delivered to the member, including records relating to disagreements, suspensions and termination of services.

The provider agency must maintain a copy of the time sheet of the attendant's delivery of services to the member. Each time sheet must be a single document that contains:

- Name of the member
- Member's identification number
- Name of the attendant who provided services to the member
- Beginning and ending dates of service delivery period
- Tasks performed for the member
- Service Schedule
- Specific days and time the attendant worked
- Signature of the attendant and the date signed. An attendant who is unable to complete or sign the time sheet may designate another person to complete or sign the time sheet. If this occurs, the provider agency must document in writing:
    1) the reason why the attendant was unable to complete or sign the time she; and,
    2) the name of the person whom the attendant authorized to complete or sign the time sheet for the attendant
- Signature of the member or representative and the date signed. A member or representative who is unable to complete or sign the time she may designate another person to complete or sign the time sheet. The provider agency must document in writing:
    1) the reason the member or representative was unable to complete or sign the time sheet; and
    2) the name of the person whom the member or representative authorized to complete or sign
    the time sheet for the member.

Appropriate PAS Billing Practices

The provider agency agrees to submit correct and appropriate billings after services have been provided. The provider agency providing PAS is entitled to payment if all services were rendered in accordance to the member's plan of care and the member is not out of town/is not an inpatient of a hospital, intermediate care facility, skilled nursing facility, state hospital, state school, or intermediate care facility for persons with mental retardation or related conditions.

Employment Assistance

Employment assistance is assistance provided to help a member locate paid employment in the community and includes:

- Identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions;
- Locating prospective employers offering employment compatible with a member's identified preferences, skills and requirements; and
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Supported Employment

Supported employment is assistance provided to an SPW member in order to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision and training related to a member's diagnosis. Supported employment is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Support Consultation

Support consultation services are available to SPW members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the Financial Management Services Agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's DR to meet responsibilities of the CDS option. Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Transitional Assistance Services (TAS)

Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings and set-up fees for utilities.

Supplemental Transition Services (STS)

Service offered through Medicaid MCOs to assist members who are transitioning from a Nursing Facility (NF) into the community, along with the support of a home and community-based services program authorized by a 1915(c) or 1115 waiver. Form H1746-A NF resident discharged from the facility into a home and community-based services program is eligible to receive up to $2,500 in STS for assistance with moving and setting up a household. STS is available on a one-time only basis and only after TAS has been exhausted.

Medical Supplies

Medical supplies are covered benefits for SPW members when needs for the member to have optimal function, independence and well-being are identified and approved by the managed care organization in the individual service plan. Medical supplies are specialized medical equipment and supplies including devices, controls or appliances specified in the plan of care that enable individuals to increase their abilities to perform activities of daily living or perceive, control or communicate with the environment in which they live. Medical supplies are reimbursed with the goal of providing individuals a safe alternative to nursing facility placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement. Medical supplies are limited to the most cost-effective items that can:

- Meet the member's needs.
-
- Directly aid the member to avoid premature nursing facility placement.
-
- Provide nursing facility residents an opportunity to return to the community.

Dental Services

Dental services for HCBS STAR+PLUS Waiver members are services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection.
- Preventive procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.
- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Nonemergency Medical Transportation (NEMT) Services What are NEMT services?

NEMT services provide transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb- to- curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Community Health Choice's vendor, Access2Care, at 844.572.8194 for more information.

Behavioral Health

Community Health Choice responsible for authorized inpatient Hospital services, this includes services provided in Freestanding Psychiatric Facilities for children in STAR and STAR+PLUS, and for adults in STAR+PLUS (for MCOs serving STAR+PLUS Members)

Targeted Case Management (TCM)

Mental Health Targeted Case Management is a community-based program. These services are provided to people with mental health disorders.

Mental Health Rehabilitative **Services (MHR)**

Mental Health Rehabilitative Services is a community-based program. These services are provided to people with mental health disorders.

Electronic Visit Verification (EVV)

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended; • Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

Community First Choice services

Community First Choice benefits provide home and community-based supports and services to certain Medicaid members with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. Members who need an institutional level of care (example: hospital, nursing facility, intermediate care facility, etc.) and who need help or want to become more independent may be eligible for CFC Services. Members living in a community-based home may be able to get these services.

Case Management for Children and Pregnant Women (CPW) services

Case Management for Children and Pregnant Women is a Medicaid State Plan benefit that assists children and pregnant women in gaining access to necessary medical, social, educational, and other service needs related to the person's health condition, health risk, or high-risk condition. Providers who render CPW services must be a Registered Nurse or Licensed Social Worker.

Annual Limit on Inpatient Services

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

Unlimited Prescriptions

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

Dual Eligible Members

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

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

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

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

For dual eligible members, claims will process according to the member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid. For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over the-counter medications), some products used in symptomatic relief of cough and colds, limited home health supplies (LHHS) and some prescription vitamins and mineral products, which are identified on the HHS Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (Texas VDP) formulary. Please note:

- A member with a Medicare Advantage plan will not affect the coverage of wrap benefits.

- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be
- covered by Medicaid without a prescription).

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

STAR+PLUS Value-Added Services

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

- Extra Help with Getting a Ride: Community Health Choice will provide additional transportation for members and family member/caregiver to appointments outside of the covered NEMT benefit, at no cost to STAR+PLUS Members as determined by Community.

- Extra Dental Benefits for Members 21 and older: Members age 21 and over receive up to
- $600 annually, towards two (2) routine dental exams per year with teeth cleaning, x-rays (once annually), non-surgical extractions and emergency exams (limited) at no cost. All additional services above and beyond those listed in this paragraph are provided to the member at a 25% discount

- Extra Vision Services: Eligible members may elect to opt-out of the standard eyewear benefit and utilize $150 to use toward the purchase of non-standard eyeglasses OR contact lenses, including disposables and contact lens fitting fees every twenty-four (24) months, with the benefit period measured from the date of service. This is a total eyewear allowance that may be applied to the Member's choice of eyeglass frame/lenses/lens options or to contact lenses in lieu of eyeglasses. Eyewear must have a prescription of at least + 0.50 diopter in at least one eye to qualify for coverage. Members who elect to purchase eyewear with a retail value greater than the $150 allowance are financially responsible for paying the participating provider's usual and customary (retail) cost of the difference between the cost of the eyewear selected and the $150 allowance.

- Discount Pharmacy/Over-the-Counter Benefits: Members receive $30 per quarter (up to $120 annually) for over-the- counter-medicines and other health related supplies not covered by Medicaid.

- Help for Members with Asthma: Community Health Choice will offer educational materials and will provide an Allergy-free mattress cover and pillowcase for members who are enrolled in Community's Disease Management/Case Management Program. Member gets one Allergy-free mattress cover and pillowcase annually.

- Extra Help for Pregnant Women: Mom Community Rewards is for pregnant women. Members receive a $25 gift card for completing a prenatal checkup within 42 days of enrollment and a
- $25 gift card for completing a timely postpartum checkup within 21- 84 days after giving birth.

- Through Mom Community Rewards, members can also access health education materials through their Community Health Choice My Member Account.

- Health and Wellness Services: Community Health Choice will provide Home delivered meals for one week after getting out of the hospital for STAR+PLUS non-waiver Members. Member may receive up to 7 meals after admission/discharge from inpatient facility.

- Home Visits: Community will provide the following additional in-home visits:
- Respite Services, up to 16 hours, annually, for STAR+PLUS non-waiver community- based Members

- Home Visits: Community will provide the following additional in-home visits:
- Companionship Visits, up to 48 hours, annually, for STAR+PLUS non-waiver community-based Members

- Health and Wellness Services: Community Health Choice will provide Home delivered meals for one week after getting out of the hospital for STAR+PLUS non-waiver Members. Member may receive up to 7 meals after admission/discharge from inpatient facility.

- Health and Wellness Services: Community will provide access to a nutritionist to provide personalized and culturally sensitive education for dietary needs and weight management and/or loss.

- Health and Wellness Services: Community Health Choice will provide access to online resources, to connect with free or low-cost community resources to address food, housing, economic and educational insecurities.

- Health and Wellness Services: Community Health Choice will provide one pill organizer for community-based members.

- Health and Wellness Services: Community Health Choice will provide one blanket to each STAR+PLUS Nursing Facility Member.

- Health and Wellness Services: Community Health Choice will provide one digital, large print clock for each newly enrolled STAR+PLUS Nursing Facility member.

- Health and Wellness Services: Community Health Choice will provide one pair non-skid socks each STAR+PLUS Nursing Facility Member.

- Healthy Play and Exercise: All Community Health Choice STAR+PLUS community-based members are eligible to join participating Baker Ripley centers in their area at no cost to the Member. Baker Ripley provides adult education, activity, and resources to promote physical, mental and spiritual wellness.

- Healthy Play and Exercise: Community Health Choice will provide an exercise/fitness kit, (which may include a resistance band, hand weight and pedometer) for all STAR+PLUS Nursing Facility members.

- Gift Programs: Community will provide incentives for achieving health targets for management of diabetes, schizophrenia, bipolar disorder and recommended yearly screenings as follows:

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

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

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

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

- Behavioral Health – Online Mental Health Resources: Community will provide online mental telehealth resources for all STAR+PLUS Members.

- Behavioral Health – Online Mental Health Resources: Community will provide an online companionship tool for all STAR+PLUS Members.

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

Service Coordination Services

Role of the Service Coordinator

The role of a service coordinator is to maximize a member's health, well-being and independence. Service coordination should consider and address the member's situation as a whole, including his or her medical, behavioral, social and educational needs. The service coordinator must work with the member's primary care provider to coordinate all covered services, noncapitated services and noncovered services available through other sources. This requirement applies even if the member is dual-eligible and the primary care provider is not in our network. In order to integrate the member's care while remaining informed of the member's needs and condition, the service coordinator must actively involve the member's primary and specialty care providers, including behavioral health service providers, and providers of noncapitated services and noncovered services.

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

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 for Level 1,2, and 3 Members

We provide a single, identified person as a service coordinator to all STAR+PLUS members who qualify as Level 1 or Level 2 under HHSC guidelines or when we determine one is required based on our assessment of the member's health and support needs. We will also provide a service coordinator to any member who requests service coordination services. Level 1 members include HCBS STAR+PLUS Waiver recipients, individuals with severe and persistent mental illness (SPMI), and other members with complex medical needs. Level 2 members include those members receiving LTSS for personal assistance services or day activity and health services (PAS and DAHS), members with non-SPMI behavioral health issues, Medicaid Breast Cancer and Cervical Program members, and Medicare and Medicaid dual-eligibles that do not qualify as Level 1. Level 3 members are those who don't qualify as Level 1 or Level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services. All members within a nursing facility will be assigned the same service coordinator. We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services. Service coordinators work with members and providers to coordinate all STAR+PLUS covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician, regardless of network status.

To speak with a service coordinator, call the Service Coordinator Hotline 1.888.435.5150., Monday-Friday from 8 a.m.-5 p.m. local time.

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.

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

There are several services that are available to Community Health Choice members based on their STAR, STAR Kids, and STAR+PLUS eligibility. Community Health Choice and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM):

- Admissions to inpatient mental health facilities as a condition of probation
- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- For STAR Kids and STAR+PLUS, HHSC hospice services
- For STAR, Texas Health Steps personal care services for members birth through age 20
- For STAR, Community First Choice (CFC) services
- PASRR screenings, evaluations and specialized services for STAR Kids and STAR+PLUS members
- HHSC contracted providers of long-term services and supports for STAR+PLUS members who have intellectual or developmental disabilities
- HHSC contracted providers of case management or service coordination services for STAR+PLUS members who have intellectual or developmental disabilities
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for STAR Kids and STAR+PLUS dual-eligible members
- For STAR+PLUS, Nursing Facility Services (non-capitated until February 28, 2015)
- For STAR Kids, nursing facility services and intermediate care facility (ICF) services
- For STAR Kids, HHSC or DSHS HCBS waiver programs authorized under Social Security Act
- §1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and home and community-based services (HCBS)

- For members who are prospectively enrolled in STAR, STAR Kids, or STAR+PLUS from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are non- capitated services, except for a stay in a chemical dependency treatment facility for STAR and STAR+PLUS members