



**Community Health Choice
HMO D-SNP 2025**

Provider Manual

Provider Services Local: 713.295.5007

Toll Free: 1.833.276.8306

Website: <https://provider.communityhealthchoice.org/medicare>

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Table of Contents

QUICK REFERENCE INFORMATION 1

Introduction 3

 About Community Health Choice 3

 Vision Statement:..... 3

 Mission Statement: 3

 Values Statement: 3

 Community Health Choice Service Areas 3

 Using the Provider Manual 3

 Code of Ethics 4

 Health Insurance Portability and Accountability Act (HIPAA) of 1996 4

 Electronic Code Sets and Standard Transactions 4

 Privacy and Security Statement 5

 Provider Participation Criteria 5

 Physician Participation Criteria 5

 Ancillary Participation Criteria 5

 Urgent Care Participation Criteria 6

 Community Health Choice Provider Portal 7

Program Overview & Objectives 7

Member Rights and Responsibilities 8

 Member Rights 8

 Member Responsibilities 9

 Member Information about Advance Directives 9

 How Members Can Designate an Authorized Representative 10

Benefits Administration & Beneficiary Protections..... 11

Provider Roles & Responsibilities..... 12

 Primary Care 12

 Role of a Primary Care Provider (PCP) 12

 PCP Responsibilities 12

 Preventive Health Services..... 12

 Behavioral Health-Related Services 13

 Additional Community Health Choice PCP Responsibilities 13

 Specialty Care 13

 Role of a Specialist..... 13

 Specialist as Primary Care Provider 14

 Specialist Responsibilities 14

 Additional Provider Responsibilities (PCP and Specialist) 15

 Updates to Contact Information 15

NPI Registry	15
Plan Termination	15
Provider Marketing Guidelines	16
Member Eligibility Verification	16
Second Opinions.....	16
Options for Member Non-Compliance	17
Appointment Availability Standards.....	17
Standards for Medical Records.....	19
Accessibility and Availability of Medical Records	19
Covered Services	21
General Description.....	21
Supplemental Benefits/Value-Added Services	22
Behavioral Health	23
Behavioral Health Appointment Accessibility Standards	24
PCP Requirements for Behavioral Health	24
Self-Referral.....	24
Behavioral Health Services	24
Mental Health Rehabilitative Services and Mental Health Targeted Case Management.....	25
Coordination between Behavioral Health and Physical Health Services	25
Medical Records Documentation.....	25
Consent for Disclosure of Information	25
Assessment Instruments for Behavioral Health: PCP Toolkit.....	26
Inpatient Discharge Follow-Up and Missed Appointment Procedures	26
Physical Health Lab/Ancillary Tests	26
Behavioral Health Focus Studies and Utilization Management Reporting Requirements.....	26
Emergency Services	26
Emergency Room Services	26
Emergency Prescription Supply	27
Emergency Transportation.....	27
Non-Emergency Medical Transportation.....	27
Pharmacy	28
Role of Pharmacy	28
Pharmacy Provider Responsibilities	28
How to Find a List of Covered Drugs	28

How to Find a List of PA Required Services and Codes	28
Process for Requesting a Coverage Determination	28
Important Information to Know About Asking for Exceptions.....	29
How We Process Coverage Determination Pharmacy Requests	29
Durable Medical Equipment and Other Products Normally Found in a Pharmacy	29
Eligibility	29
Verifying Member Enrollment in Community Health Choice (HMO D-SNP) Plan	29
Verifying Community Health Choice Member Eligibility.....	30
Community Health Choice (HMO D-SNP) ID Card	30
Enrollment in Community Health Choice (HMO D-SNP)	30
Disenrollment from Community Health Choice (HMO D-SNP).....	31
Authorization for Health Services	31
Prior Authorization.....	31
Services Requiring Authorization.....	31
InterQual	31
Authorization Requests.....	31
Failure to Obtain Prior Authorization.....	32
Authorization for Out-of-Network Services.....	32
Continuity of Care	32
Pregnant Woman Information	32
Continuity of Care – Medicare Members	32
Member Moves Out of Service Area	32
Pre-Existing Conditions	33
Case Management.....	33
Quality Management.....	33
Quality Improvement Program	33
Quality Improvement Committees	34
Quality Improvement Studies	34
Quality Improvement Projects	34
Care Transitions	35
Special Access Requirements	35
Interpreter/Translation Services	35
MCO/Provider Coordination	36
Reading/Grade Level Consideration	36

Cultural Sensitivity	36
Network Referrals	37
Referral to Specialists and Health-Related Services	37
Referral to Network Facilities and Contractors.....	37
Dispute Resolution for Providers	37
Disputes Involving Administrative Matters.....	37
Disputes Concerning Professional Competence or Conduct.....	37
Provider Credentialing and Recredentialing	40
CAQH ProView	40
CAQH-Approved Provider Types	40
Billing and Claims	41
Timely Filing.....	41
Electronic Code Sets and Standard Transactions	41
Electronic Claims	41
Submitting Claims by Mail.....	41
Claim Format Standards.....	41
Ordering, Referring, and Prescribing Providers.....	42
Rendering Provider Requirement	42
Adjudication of Claims	42
Claims Encounter Data.....	43
Explanation of Payment (EOP)/Remittance Advice (RA)	43
Non-Payment/Claim Denial	43
Pricing of Inpatient Claims	43
SNF Consolidated Billing	43
Processing Hospice Claims.....	43
Hospice-Related Services	44
Non-Hospice Services.....	45
Sequestration.....	45
Claims Audits.....	45
Provider Preventable Conditions	46
Pass-Through Billing	46
Emergency Services Claims	46
Out-of-Network Provider Payments	46
CLIA	47

Community Health Choice Claims Payment Options.....	47
Coordination of Benefits.....	47
Reconsiderations.....	48
Special Considerations for Dual Eligible Members	48
Provider Payment Disputes	48
Claims Questions/Status.....	48
Provider Payment Dispute	48
Billing Members	50
Member Acknowledgement Statement	50
Provider Complaints and Appeals	51
Provider Complaints Process	51
Documentation	51
Provider Complaints Process to CMS	51
Provider Appeals Process.....	51
Appeal of an Adverse Determination.....	51
Expedited Appeals Procedures for Medical Necessity.....	52
Documentation	52
Member Complaints and Appeals	53
Member Complaint Process.....	53
How to File a Complaint.....	53
Requirements and Time Frames for Filing a Complaint	53
Can someone from Community Health Choice help my Member file a complaint, appeal or expedited appeal?	53
What can I do if Community Health Choice denies or limits my Patient’s request for a Covered Service?	53
Member Appeal Process.....	54
How to File an Appeal	54
Time Frame for Filing an Appeal	54
Time Frame for Resolution of an Appeal	54
How will I find out if pre-service appeal is denied?	54
When can a Member request an appeal handled by an Administrative Law Judge or attorney adjudicator?	55
Expedited Member MCO Appeal.....	55
Right to an Expedited Appeal.....	55
How to File an Expedited Appeal	55
Resolution Time Frame for an Expedited Appeal.....	55
What if Community Health Choice denies the request for an Expedited Appeal?.....	55
Reporting Fraud, Waste, or Abuse by a Provider or Member	55
General Obligation to Prevent, Detect, and Deter Fraud, Waste, and Abuse	55
Importance of Detecting, Deterring, and Preventing Fraud, Waste, and Abuse	56
Health Insurance Portability and Accountability Act.....	57
Do you want to report Fraud, Waste, or Abuse?	57
To report Fraud, Waste or Abuse, choose one of the following:	58

To report Fraud, Waste or Abuse, gather as much information as possible.....	58
Community Health Choice’s Special Investigation Unit.....	58
How to Report Health Care Fraud to Community Health Choice’s SIU.....	58
Reporting Abuse, Neglect or Exploitation (ANE)	59
Report suspected Abuse, Neglect, and Exploitation	59
Model of Care Training	60
Care Transitions	61
The Community Health Choice (HMO D-SNP) Provider Network.....	61
Quality Program and Performance Improvement.....	61

QUICK REFERENCE INFORMATION

Provider Services	<p>For general questions or to submit your updates: Phone: 713.295.5007 Toll Free: 1.833.276.8306 www.CommunityHealthChoice.org/Medicare Email: ProviderWebInquiries@CommunityHealthChoice.org Or contact your Provider Engagement Representative.</p>
Community Health Choice Website	<p>www.CommunityHealthChoice.org/Medicare https://Provider.CommunityHealthChoice.org/</p> <p>The site offers general information and various tools that are helpful to the Provider such as:</p> <ul style="list-style-type: none"> • Prior Authorization Requirements • Provider Manual • Provider Directories • Provider Newsletters • Downloadable Forms
Member Services and Specialist Scheduling	<p>Phone: 713.295.5007 Toll Free: 1.833.276.8306</p> <ul style="list-style-type: none"> • Benefit Coverage and Eligibility Verification • Physician Information • Service Questions • Interpreter Services • Specialist Referral Assistance
Claims Inquiries or Adjudication	<p>Phone: 713.295.5007 Toll Free: 1.833.276.8306 Community Health Choice will accommodate three claims per call. Unlimited inquiries on website</p>
Utilization Management (Medical)	<p>Phone: 713.295.5007 Fax: 713.295.7059</p>
Utilization Management (Behavioral Health)	<p>Phone: 1.877.343.3108 Fax: 713.576.0932 (inpatient) Fax: 713.576.0939 (outpatient) Fax: 713.848.6941 (inpatient discharge)</p>
Care Management/Disease Management: Asthma, Diabetes, High-Risk Pregnancy, Congestive Heart Failure	<p>Phone: 832.CHC.CARE (832.242.2273) Fax: 713.295.7028 or 1.844.247.4300 E-mail: CMCoordinators@CommunityHealthChoice.org</p>
Case Management: Behavioral Health	<p>Phone: 713.295.5007 Fax: 713.576.0933 E-mail: BHCasemanagementreferrals@CommunityHealthChoice.org</p>
Report High Risk Pregnancy or Sick Newborn	<p>Phone: 713.295.2303 Toll Free: 1.888.760.2600 Fax: 713.295.7028</p>
Peer-to-Peer Discussions	<p>Phone: 713.295.2319</p>
Outpatient Perinatal Authorizations	<p>Phone: 832.242.2273 Fax: 713.295.7016 or 1.844.247.4300</p>

Mailed Claims	Community Health Choice Attn: Claims P.O. Box 301404 Houston, TX 77230
Refund Lockbox	Community Health Choice P.O. Box 4818 Houston, TX 77210-4818
Electronic Claims	Payer ID: 48145 <ul style="list-style-type: none"> • Change HealthCare Solutions, Inc. (formerly Emdeon/Relay Health): 1.877.469.3263 • Availity: 1.800.282.4548 • Gateway/TriZetto Provider Solutions: 1.800.969.3666
Adverse Determination and Appeals (Medical)	Community Health Choice Attn: Medical Appeals 4888 Loop Central Drive, Ste.600 Houston, TX 77081 Fax: 713.295.7033 (Standard Medical Appeals) 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 (Behavioral Health Standard Appeal Requests) Fax: 713.576.0935 (Behavioral Health Expedited Appeal Requests) All appeals must be in writing and accompanied by medical records.
Behavioral Health – Crisis Line (Members)	Toll Free: 1.877.343.3108
Dental Services	FCL Dental: Provider Services 1.877.493.6282
Lab	Members can go to any of these preferred laboratories: <ul style="list-style-type: none"> • Clinical Pathology Laboratories, Inc. • LabCorp • Quest Diagnostics
Pharmacy	Navitus Health Solutions 1.866.270.3877 www.Navitus.com
Vision Services	Envolve Vision: Customer Service (Member Eligibility and Claims Inquires): 844.686.4358 Network Management (Provider Participation): 1.800.531.2818
Non-Emergency Medical Transportation	MTM Health 844.572.8194
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 more than 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
- Marketplace plans for individuals, including subsidized plans for low-income families
- Medicare Dual Special Needs Plan (D-SNP) Program for Medicare managed care recipients who are also eligible for Medicaid, and for whom HHSC has a responsibility for payment of Medicare Cost Sharing Obligations under the Texas State Plan Qualified Medicare Beneficiary (QMB) and QMB Plus Plans
- 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 URAC Health Plan accreditation for its Medicaid, CHIP, and Marketplace lines of business. An affiliate of the Harris Health System, Community Health Choice is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.

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

Vision Statement:

Our vision is a healthy life for every Texan.

Mission Statement:

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

Values Statement:

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

Community Health Choice Service Areas

Community Health Choice (HMO D-SNP) service area includes the following counties in Texas: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton.

Using the Provider Manual

The Provider Manual is designed as an informational and procedural guide for Community Health Choice Participating Providers and their staff, for Community Health Choice's contracted facilities, and for Community Health Choice's Ancillary Providers. 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 followed, this manual will decrease the paperwork and time your staff spends:

- Researching details of the Community Health Choice (HMO D-SNP) program
- Obtaining prior authorizations for certain services
- Re-billing 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 www.CommunityHealthChoice.org/Medicare. Updates and new services may be added periodically to the Manual as required by law, rule or regulation. Community Health Choice will post the revised information on our website from which you can print the revisions, if desired. Likewise, when Community Health Choice develops new policies/procedures or clinical practice guidelines, Community Health Choice will post the most current versions on our website and alert Providers of their availability. 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 713.295.5007 or from your Provider Engagement

Representative. The Provider Manual is designed solely as a guide. If differences, errors or omissions occur between

this manual and either the

Provider's contract or the HHSC policies and regulations, the Provider contract and HHSC policies and regulations shall govern. The Community 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.

As an additional reference, Providers may use the Texas Medicaid Provider Procedures Manual (TMPPM) online at TMHP.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. This website provides the most current information about Texas Medicaid benefits, policies, and procedures. It also contains the most recent updates in the Medicaid Provider Bulletins section, released every other month.

Code of Ethics

Community 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 further this goal, Community Health Choice Network Providers shall:

- Treat all Members with respect and courtesy.
- Respond promptly to Member questions.
- Ensure that Members have reasonable access to the services to which they are entitled under their health plan
- Assist Members (or their legal guardians, when appropriate) with making informed decisions about their medical care, including providing them with information about withholding resuscitative services, foregoing or withdrawing life- sustaining treatment or participating in studies or clinical trials. Providers, as required by law, shall obtain informed consent.
- In making clinical decisions concerning a Member's medical care, a Community 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 Member's 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 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 www.CommunityHealthChoice.org/medicare.

Provider Participation Criteria

Community Health Choice maintains Provider Participation Criteria for physicians, facility, ancillary, and urgent care Providers.

For information related to Medicaid provider participation, visit <https://provider.communityhealthchoice.org/resources/>.

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	Additional Notes
Regulatory	Attested NPI Number (required)	
	Medicare Number	
	Answering Service – Access to live person or callback from live person within 30 minutes of call	
	Not currently on govt. exclusion or preclusion list	
Administrative	Internet Access – office/patient care setting	
	Facsimile	
	Hospital privileges at participating hospital or surgery center	Or advanced approval of acceptable coverage (e.g., hospitalist or designation)
	Submission of authorization requests via Provider Portal	
	EDI – Electronic Claims Submission	Through existing clearinghouse partnerships
	EDI – Electronic Funds Transfer	
	EDI – Electronic Remittance Advice	
	Adherence to HIPAA Standard Transactions	
	Participation in CAQH program	
	Electronic Medical Record (EMR)	

Ancillary Participation Criteria

The following participation criteria apply 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	Additional Notes
Administrative	Valid Texas Medicaid Number (required)	
	Valid Medicare Number (required)	
	At least one line dedicated for facsimile	
	Submission of authorization requests via Provider Portal	
	EDI - Electronic Claims Submission	Through existing clearinghouse partnerships
	EDI - Electronic Remittance Advice	
	EDI - Electronic Funds Transfer	
	Electronic Medical Record (EMR)	
Regulatory	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	
	Not currently on govt. exclusion or preclusion list	

Urgent Care Participation Criteria

The following participation criteria apply 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	Additional Notes
Administrative	Has valid Texas Medicaid Number	
	Has valid Medicare Number	
	Internet access - office/patient care setting	
	Facsimile	
	Electronic Medical Record (EMR)	
	Electronic submission of prescriptions (e-Prescribe)	
	Answering Service - Access to live person or callback from live person within 30 minutes of call	
	EDI - Electronic Claims Submission	Through existing clearinghouse partnerships
	EDI - Electronic Funds Transfer	
	EDI - Electronic Remittance Advice	
	Visit summary to PCP within 24 hours or next business day	
	Adherence to HIPAA Standard Transactions	
	Onsite services (i.e., lab, x-ray, etc.)	

	Accreditation - Urgent Care Association of America (UCAOA)	
	Certification - Certified Urgent Care (CUC) Program	
Regulatory	Not currently on govt. exclusion or preclusion list	

Community Health Choice 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 view claim status, as well as Member eligibility, benefits, and the status of pre-authorizations. To access the Provider Portal, visit www.CommunityHealthChoice.org/Medicare, click on the Provider tab, and then "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.

Program Overview & Objectives

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

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

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

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

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

When a person is entitled to both Medicare and medical assistance from a State Medicaid plan, they are considered dual eligible. As a dual eligible, beneficiary services are paid first by Medicare and then by Medicaid. Medicaid coverage varies depending on income, resources, and other factors. Benefits may include full Medicaid benefits and/or payment of some or all of the Member's Medicare cost-share (premiums, deductibles, coinsurance, or copays).

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

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

Member Rights and Responsibilities

Member Rights

- A Member has the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - Be treated fairly and with respect.
 - Know that their medical records and discussions with their Providers will be kept private and confidential.
- A Member has the right to see the information in their medical records and know how it has been shared with others.
- If a Member feels they have been treated unfairly or their rights are not being respected, they have the right to call the Office for Civil Rights, Community Health Choice Member Services, the State Health Insurance Assistance Program or Medicare.
- A Member has the right to a reasonable opportunity to choose a healthcare plan and PCP. The PCP is the doctor or healthcare Provider they will see most of the time and who will coordinate their care. A Member has the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
- Be told how to choose and change their health plan and PCP.
- Choose any health plan they want that is available in their area and choose their PCP from that plan.
- Change their PCP.
- Change their health plan during open enrollment or special election period without penalty.
- A Member has the right to ask questions and get answers about anything they do not understand. That includes the right to:
 - Have their Provider explain their healthcare needs to them and talk to them about the different ways their healthcare problems can be treated.
 - Be told why care or services were denied and not given and receive written explanation of why services were denied.
- A Member has the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - Work as part of a team with their Provider in deciding what health care is best for them.
 - Say yes or no to the care recommended by their Provider.
 - Know the risks.
 - A Member has the right to receive instructions about what is to be done if they are not able to make medical decisions for themselves.
- A Member has the right to use each available complaint and appeal process through the managed care organization, through Medicare, and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
 - Make a complaint to Community Health Choice, to Medicare or to the state Medicaid program about their health care, their Provider, or Community Health Choice.
 - Use the plan's appeal process and be told how to use it.
 - Ask for a fair hearing from the state Medicaid program or the appeals process allowed under the D-SNP program, and get information about how that process works.
- A Member has the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care they need.
 - Get medical care in a timely manner. Community Health Choice, and its contracted Providers, are responsible for ensuring that a Member has timely access to covered services and drugs.
 - Be able to get in and out of a healthcare Provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - Have interpreters, if needed, during appointments with their Providers and when talking to Community Health Choice. Interpreters include people who can speak in their native language, help someone with a disability, or help them understand the information.
- Have plan information provided in a way that works for them, including Braille, large print, or other alternative formats.

- Be given information they can understand about Community Health Choice rules, including the healthcare services they can get and how to get them, networks Providers and network pharmacies, and about why something is not covered and what they can do about it.
- A Member has the right to not be restrained or secluded when it is for someone else's convenience, to force them to do something they do not want to do or punish them.
- A Member has a right to know that doctors, hospitals, and others who care for them can advise them about their health status, medical care, and treatment. Community Health Choice cannot prevent them from giving them this information, even if the care or treatment is not a covered service.
- A Member has a right to know that they are not responsible for paying for covered services. Doctors, hospitals, and others cannot require them to pay copayments or any other amounts for covered services when there is no Member liability. Providers cannot balance bill a Member.

Member Responsibilities

- A Member must learn and understand each right they have under the Medicare program. That includes the responsibility to:
 - Ask questions if they do not understand their rights.
 - Learn what choices of health plans are available in their area.
- A Member must abide by Community Health Choice, Medicare, and Medicaid policies and procedures. That includes the responsibility to:
 - Learn and follow their health plan, Medicare, and Medicaid rules.
 - Choose their health plan and a PCP quickly.
 - Make any changes in their health plan and PCP in the ways established by Medicaid and by Community Health Choice.
 - Keep their scheduled appointments.
 - Cancel appointments in advance when they cannot keep them.
 - Always contact their PCP first for their non-emergency medical needs.
 - Be sure they have approval from their PCP before going to a specialist.
 - Understand when they should and should not go to the emergency room.
- A Member must share information about their health with their PCP and learn about service and treatment options. That includes the responsibility to:
 - Tell their PCP about their health.
 - Talk to their Providers about their healthcare needs and ask questions about the different ways their healthcare problems can be treated.
 - Help their Providers get their medical records.
- A Member must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
 - Work as a team with their Provider in deciding what health care is best for them.
 - Understand how the things they do can affect their health.
 - Do the best they can to stay healthy.
 - Treat Providers and staff with respect.
 - Talk to Providers about all medications, both prescription and non-prescription.

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 can also prolong the process of dying.

A Member has the right to make advance 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 behavioral 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 behavioral 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.

How Members Can Designate an Authorized Representative

Individuals who represent Community Health Choice (HMO D-SNP) Members may either be appointed or authorized to act on behalf of the Member in filing a grievance, requesting an initial determination or in dealing with any of the levels of the appeals process. The chart below outlines who can appoint a representative, who can serve as a representative, and the documentation required by Community Health Choice before the appointment of representative is considered valid.

Who can Appoint a Representative	Who can Act or be Appointed as a Representative	Requirement for Representation
Member	Any individual (e.g., relative, friend, advocate, attorney)	The Member must submit <u>Form CMS-1696</u> , Appointment of Representative (AOR), or an equivalent written notice (hereinafter, collectively referred to as a representative form).
A court acting in accordance with state or other applicable law	An individual authorized by the court. Could include, but is not limited to: <ul style="list-style-type: none"> • Court-appointed guardian • Individual with durable power of attorney • A healthcare proxy • A person designated under a healthcare consent statute • Executor of an estate 	A representative form is not required. <ul style="list-style-type: none"> • Authorized individual must produce appropriate legal papers supporting his or her status under state law.

All AORs are valid for one year from the date the AOR or equivalent written notice is signed by both the Member and the appointed authorized representative, unless revoked before the one-year expiration date.

Appointment of Representative – Written Request Equivalent to CMS Form 1696

Community Health Choice accepts Appointment of Representative (AOR) requests from its Members that are either on the CMS Form 1696 or an equivalent written notice. The AOR form can be located at this link

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or via the Provider Portal at www.CommunityHealthChoice.org/Medicare. The form is also available in Spanish. If a Member elects not to use the AOR form, s/he can submit an equivalent written notice. The equivalent written notice must include the following

elements:

- Name, address, and telephone numbers of the Member and the individual being appointed;
- Member's Medicare Beneficiary Identifier, or plan ID number;
- The appointed representative's professional status or relationship to the party;
- A written explanation of the purpose and scope of the representation;
- A statement that the Member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- A statement by the individual being appointed that he or she accepts the appointment; and
- Is signed and dated by the Member and the individual being appointed.

Benefits Administration & Beneficiary Protections

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

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

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

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

Provider Roles & Responsibilities

Primary Care

Role of a Primary Care Provider (PCP)

A PCP provides primary medical care and preventive health services and is the Member's initial contact point when accessing health care. It is a partnership among the Member, the PCP, and the extended network of consultative and specialty Providers with whom the PCP has an ongoing and collaborative relationship. The PCP is knowledgeable about the Member's specialty care, health-related social and educational needs, and is connected with necessary resources in the community that will assist the Member in meeting those needs. The PCP maintains the primary relationship with the Member, keeps abreast of the current status of the Member through a planned feedback mechanism, and accepts them back into their practice for continuing primary medical care and preventive health services.

PCPs may include the following specialties:

- General Practitioners
- Family Practitioners
- Internists
- Geriatrics
- Pediatricians
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Nurse practitioners (NP) (under the supervision of a licensed practitioner)
- Specialists (for Members with special medical or behavioral needs)

PCP Responsibilities

The PCP either furnishes or arranges for all the Member's healthcare needs, including well checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services. Community Health Choice (HMO D-SNP) 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 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 specialists 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.
- Directing 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). Directed care should be a covered benefit or service, and you are responsible for obtaining prior authorization (when required) or facilitating prior authorization through the submission of medical records or other medical documentation that supports the medical necessity of the requested benefit or service.
- Coordinating utilization of services and monitoring the progress of care to facilitate the return to the PCP as soon as medically appropriate.
- Participating in assigned Member's Interdisciplinary Care Team (ICT) by attendance at ICT meetings, providing input to Community prior to the meeting, and/or recommending updates to the Member's Individualized Care Plan developed through the Community health risk assessment process. Complying with Quality Improvement Programs, which may include periodic chart reviews.
- Maintaining an open panel for Membership. If needing to be changed, PCP must notify Community Health Choice.
- Completing required annual training, including but not limited to training on the Community Model of Care.

Preventive Health Services

Providers must provide preventive health services in accordance with the Medicare Advantage D-SNP program and related medical policies. Refer to the Covered Services section of this manual.

- Annual well checkups for all adult Community Health Choice Members over the age of 21
- Preventive services as indicated by the U.S. Preventive Services Task Force
- Education of Members about their right to self-refer to any network OB/GYN Provider for OB/GYN health-related care

Behavioral Health-Related Services

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 their scope of practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues. For assistance or referral for behavioral health services, PCPs may contact the Behavioral Health crisis line 24/7 at 1.877.343.3108 or Provider Services at 713.295.5007 during business hours.

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
- 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
- Agree not to refer or direct patients to hospital emergency rooms for non-emergent medical services at any time, and not to refer or direct patients to hospital emergency rooms for urgently needed care when the service can be provided during business hours by your office or an urgent care setting
- 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, as specified in the Provider Agreement
- Meet all Community Health Choice credentialing and re-credentialing requirements
- Permit release of confidential information only under circumstances as required by the Provider Agreement, and applicable federal or state laws, rules or regulations
- Maintain all medical records relating to Community Health Choice Members for a period of at least 10 years from the 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

Specialty Care

Role of a Specialist

Specialists are responsible for treating Members who have been sent to them by participating PCPs. Specialists should:

- Provide specialty services upon request from the PCP
- Work closely with the PCP to enhance continuity in health services to Community Health Choice Members
- Advise the PCP in writing regarding findings in a consultation, recommendations or an ongoing treatment program
- Notify the PCP if another specialist is needed
- Notify the PCP and Community Health Choice when a specialist wants to admit a Member to a hospital, and relay information necessary to authorize the admission. Community Health Choice does not require a referral for in-network specialists to treat Members.

Please confirm Member eligibility by calling Community Health Choice Member Services at 713.295.5007 or

1.833.276.8306 or access eligibility information on our website at www.CommunityHealthChoice.org/Medicare. 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 713.295.5007.

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:

- Terminal cancer
- HIV/AIDS
- Progressive neurological diseases
- 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 713.295.5007 or 1.833.276.8306 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 713.295.5007.

Specialist Responsibilities

Specialists are responsible for furnishing medically necessary services to Community Health Choice Members at the request of 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 applicable 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 specialists within the established standards. When a Community Health Choice Member is sent to a specialist by his/her PCP, the specialist should review the case with the PCP to determine clearly what services are being requested.

To authorize services, please call 713.295.5007, fax 713.295.7059 or submit an authorization online at www.CommunityHealthChoice.org/Medicare.

Specialist(s) may be requested to participate in a Member's Interdisciplinary Care Team (ICT) by attendance at ICT meetings, providing input to Community prior to the meeting, and/or recommending updates to the Member's Individualized Care Plan developed through the Community health risk assessment process. Participation in the ICT requires completion of training on the Community Model of Care.

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 specialist, the Provider shall ensure that contracted services are provided under this agreement at the specialist's office during normal business hours and be available to Members by telephone 24 hours a day, seven days a week, for consultation on medical concerns.

Additional Provider Responsibilities (PCP and Specialist)

Updates to Contact Information

Please contact Community Health Choice 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
- Medicare Provider number
- DEA number
- NPI 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 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 timeframe, 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-
Contracting 4888 Loop Central Drive,
Ste.600 Houston, TX 77081
Fax: 713.295.7058
E-mail: CHC.Contracting@CommunityHealthChoice.org

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 date of change. Requests received before the 15th of the month will become effective on the first day of the following month following the request. 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. PCPs and specialists are requested to continue care in progress until all Members can be successfully transferred to new Providers. Community will notify Member of continuity of care rights when applicable.

Provider Marketing Guidelines

Community network Providers should adhere to the following when responding to patient requests or when interacting with the patient during their course of treatment.

Providers **are not allowed** to do the following:

- Accept or collect scope of appointment forms
- Accept Medicare enrollment applications
- Engage in any form of communication with patient to persuade them to enroll in a specific plan based on financial or any other interest of the Provider
- Mail marketing materials on behalf of Community
- Offer any type of inducements to persuade patients to enroll in Community Health Choice plans or select them as a Provider
- Conduct health screenings as a marketing activity
- Distribute Community marketing materials or applications in areas where care is being delivered
- Accept compensation from Community for any marketing or enrollment

activities Providers **are allowed** to do the following:

- Distribute unaltered printed materials created by Medicare such as Medicare Plan Finder, Medicare & You Handbook or Medicare Options Compare in areas where care is delivered.
- Provide the name of health plan(s) in which the Provider is contracted or is a participating Provider.
- Answer questions or discuss the merits of Medicare plans, including cost sharing or benefits in areas where care is delivered.
- Provide patients with contact information for State Health Insurance Assistance Program (SHIP), plan marketing representative, State Medicaid, local Social Security Office or Medicare.
- Refer patients to Community or other plan information available in common areas.
- Provide information and assistance in applying for Low Income Subsidy (LIS).
- Make available, distribute, and display **communication** materials in common areas and in areas where care is being delivered.
- Provide or make available Community **marketing** materials only in common areas such as common entryways, vestibules, hospital/nursing home cafeteria, community/recreational or conference rooms.

Member Eligibility Verification

It is the responsibility of the treating Provider to verify that the patient continues to be a Community Health Choice Member during the treatment period. Information about eligibility verification can be found in the Eligibility section of this manual or by calling Community Health Choice Member Services at 713.295.5007 or 1.833.276.8306.

Second Opinions

A Member, AOR, 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.

Options for Member Non-Compliance

Contact Provider Services at 713.295.5007 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

The 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 by 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.

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
Initial Outpatient Behavioral Health Visit	Must be provided within 14 days
Preventive Care Physical/Wellness Exams	Adults (21 years and older): Within 90 days New Members: Within 90 days of enrollment

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

- Health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) is in

serious jeopardy

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

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

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

PCP 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 includes prenatal care and birth.
- Immunizations: 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 Community Health Choice (HMO D-SNP) program and (2) prior admissions, as necessary.
- For medical records of adults, the medical record documents whether the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- Documentation: Documentation of evidence and results of medical, preventive, and behavioral health screening; documentation of all treatment provided and results of such treatment; documentation of the team members involved in the multidisciplinary team of a Member needing specialty care; and 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 healthcare 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 Member 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 section above.

Covered Services

General Description

The following information provides an overview of benefits available to Community Health Choice Members enrolled in the Community Health Choice (HMO D-SNP) program. Please refer to the Member's Explanation of Coverage for a comprehensive listing of limitations and exclusions that apply to each benefit category.

Services that are covered:

- Abdominal aortic aneurysm screening (preventive service)
- Ambulance services
- Annual wellness visit (preventive service)
- Bone mass measurement (preventive service)
- Breast cancer screening (mammograms) (preventive service)
- Cardiac rehabilitation services
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) (preventive service)
- Cardiovascular disease testing (preventive service)
- Cervical and vaginal cancer screening (preventive service)
- Chiropractic services
- Colorectal cancer screening (preventive service)

- Depression screening (preventive service)
- Diabetes screening (preventive service)
- Diabetes self-management training, diabetic services, and supplies (preventive service)
- Durable medical equipment (DME) and related supplies
- Emergency care
- Hearing services
- HIV screening (preventive service)
- Home health agency care
- Hospice care
- Immunizations (preventive service)
- Inpatient hospital care
- Inpatient behavioral health care
- Inpatient stay: covered services received in a hospital or SNF during a non-covered inpatient stay
- Medical nutrition therapy (preventive service)
- Medicare Diabetes Prevention Program (MDPP) (preventive service)
- Medicare Part B prescription drugs
- Obesity screening and therapy to promote sustained weight loss (preventive service)
- Opioid treatment program services
- Outpatient diagnostic tests and therapeutic services and supplies
- Outpatient hospital observation
- Outpatient hospital services
- Outpatient behavioral health care
- Outpatient rehabilitation services
- Outpatient substance abuse services
- Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers
- Partial hospitalization services
- Physician/Practitioner services, including doctor's office visits
- Podiatry services
- Prostate cancer screening exams (preventive service)
- Prosthetic devices and related supplies
- Pulmonary rehabilitation services
- Screening and counseling to reduce alcohol misuse (preventive service)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (preventive service)
- Services to treat kidney disease
- Skilled nursing facility (SNF) care
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (preventive service)
- Supervised Exercise Therapy (SET)
- Urgently needed services
- "Welcome to Medicare" preventive visit (preventive service)
-

Supplemental Benefits/Value-Added Services

Community Health Choice offers the following Supplemental Benefits:

- **Dental** – Dental care is provided through FCL Dental. The Provider Directory can be found here: www.CommunityHealthChoice.org/Medicare. Their Provider Services phone number is 1.877.493.6282. Benefits:
 - Comprehensive Dental Coverage – non-routine services, diagnostic services, restorative services, periodontics, and extractions
 - Preventive Dental Coverage – oral exams and prophylaxis (cleaning) one time every six months; dental X-rays one time per year

Limitation: Maximum plan benefit amount: \$3,500/year

- **Vision** – Vision care is provided through Envolve Vision. The Provider Directory can be found here: www.CommunityHealthChoice.org/Medicare. Their Network Management (Provider Participation) phone number is: 1.800.531.2818.

Benefits:

- Routine eye examination with refraction testing for the purpose of obtaining eyeglasses and/or contact lenses once every twelve (12) months
- Up to \$150 per year for total eyewear (contact lenses and lenses/frames combined)

- **Transportation Services** – Transportation for doctors' appointments when approved by Community Health Choice's case manager. The Member must call Community Health Choice for approval at least three business days before the Member's appointment.

Benefits:

- Members receive 36 one-way trips per year.

- **Meal Benefit** – Prior authorization and referral required to confirm medical condition or other qualifying event when approved by Community Health Choice's case manager.

Benefits:

- Seven days, 14 meals immediately following surgery or an inpatient hospital stay, provided they are ordered by a physician or non-physician practitioner. The Provider should refer the Member to community and social services for further meals, if needed, or
- For a chronic condition, including but not limited to cardiovascular disorders, COPD or diabetes, for a temporary period, typically two weeks, per enrollee per year provided they are ordered by a physician or non-physician practitioner and are part of a supervised program designed to transition the enrollee to life style modifications.
- Home delivery of meals may be offered as a supplemental benefit if the services are:
- Needed due to an illness;
- Consistent with established medical treatment of the illness; and
- Offered for a short duration.
- Social factors, by themselves, do not qualify an enrollee for meal services.

- **Over the Counter (OTC) Allowance** - Coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages.

Benefits:

- \$75 per Member, per quarter

Behavioral Health

Behavioral health services are covered services for the treatment of mental, emotional, chemical dependency or substance abuse disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or ICD classification systems. Those services include treatment at inpatient, outpatient, and professional 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 behavioral health or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare

- Provided in the safest, most appropriate and least restrictive setting
- Not omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered
- Not experimental or investigative.
- Not primarily for the convenience of the Member or Provider.

Behavioral Health Appointment Accessibility Standards

Service	Appointment Accessibility
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

PCP Requirements for Behavioral Health

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

Providers can call Community Health Choice at 713.295.5007 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 713.295.5007 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 713.295.5007 or
- Faxing referral information to our dedicated behavioral health fax lines 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 for the treatment of behavioral 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 behavioral 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 Community Health Choice (HMO D-SNP) Members who require these services based on the appropriate standardized assessment, the Adult Needs and Strengths Assessment (ANSA).

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.

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. The 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 health care 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's 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. Member information may only be released after the Member or the Member's LAR provides a written release of information.

Assessment Instruments for Behavioral Health: PCP Toolkit

Community developed a comprehensive PCP Toolkit for PCPs to assist in identifying and treating behavioral health issues. It includes information on the most common behavioral health issues, including guidelines for diagnosis and treatment, fact sheets for Members, and assessment tools. Delivering behavioral health services in a primary care setting can help reduce the stigma associated with behavioral 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 behavioral health 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

Providers should utilize participating laboratory vendors to provide analysis of labs related to outpatient behavioral health 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

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, either by calling 713.295.5007 or 1.833.276.8306 or by faxing the encounter record to 713.295.2284. 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

In those instances when a Federal or State disaster is declared, Community Health Choice will temporarily lift the “refill too soon” edit. Affected pharmacies will receive a rejected claim if the Member attempts to fill a medication sooner than normally allowed. Upon receipt of the rejection, pharmacies can resubmit the claim by entering ‘13’ in the Submission Clarification Code (SCC) Field.

Emergency Transportation

The ambulance transport is an emergency service when the condition of the Member 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 Medical Transportation

Member can receive non-emergent medical transportation services through MTM Health. Transportation appointments must be scheduled prior to the appointment, at a minimum of 48 hours, or 2 full business days. To find out how a member can get a ride to his/her doctor appointment, please reference the contact information below:

- Members can schedule a ride through (reservations): 844.572.8194
- 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

Trip management can be accomplished by accessing MTM Health online ordering system or through the member app. The link to

MTM Health’s online system can be found on the Community Health Choice provider portal.

If the Member has an urgent need for transportation, such as Hospital Discharges, Pharmacy Services, and Urgent Care Facilities, transportation will be approved with a 3 hour notification time (Urgent Care Facilities must be nearest in-network facility); all other services needed in less than 48 hours will need approval.

Pharmacy

Pharmacy benefits for Community Health Choice Members are administered by Navitus Health Solutions (Navitus), 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 1.866.270.3877 or visit www.CommunityHealthChoice.org/Medicare. The Community Health Choice Plan formulary adheres to all Medicare requirements and includes prescription drugs that are found to be safe and economical by a committee of prescribers and pharmacists called the Pharmacy and Therapeutics (P&T) Committee. The formulary includes one tier of coverage.

Role of Pharmacy

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

Members have the right to obtain medication from any network pharmacy. A complete list of participating pharmacies is available on the Community Health Choice Plan website at www.CommunityHealthChoice.org/Medicare or by calling Navitus customer care 1.866.270.3877.

Pharmacy Provider Responsibilities

Pharmacy Provider will fill prescriptions according to the prescriber's directions and coordinate with the prescribing physician to assure the authenticity of the prescription drug order. Pharmacy Provider will ensure Members receive all medications for which they are eligible by ensuring reasonable verification of the identity of the Member, prescriber, and if appropriate, caregiver.

Pharmacy Provider must provide coordination of benefits when a Member also receives Medicaid services or other insurance benefits.

How to Find a List of Covered Drugs

To get the most complete and current information about which drugs are covered, you can visit the plan's website. The formulary is available at www.CommunityHealthChoice.org/Medicare.

How to Find a List of PA Required Services and Codes

Some medications do require prior authorization. More information is available at www.CommunityHealthChoice.org/Medicare. On the formulary, medications that have additional requirements/limits are identified in the Drug List.

Process for Requesting a Coverage Determination

A coverage determination is an initial coverage decision made by Community Health Choice regarding Medicare Part D prescription drug coverage. Coverage determination requests about Part D drugs include:

- Asking Community Health Choice to pay for a prescription drug that has already been bought and is believed to be covered.
- Asking whether a drug is covered and whether the applicable coverage rules have been satisfied. (For example, when a drug is on Community Health Choice's List of Covered Drugs but requires approval before it is covered.)
- Asking for an exception. (If a drug is not covered in the way a Member would like it to be covered, a request can be made to Community Health Choice to make an exception.) Examples include:
 - Asking to cover a drug that is not on the formulary drug list
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
 - Asking to remove the extra rules and restrictions on Community Health Choice's coverage for a drug such as:
 - Being required to use the generic version of a drug instead of the brand name drug
 - Getting Community Health Choice approval for a drug when the prior authorization criteria have been met

- Quantity limits
-

Important Information to Know About Asking for Exceptions

The Member (or their representative), the doctor or other prescriber may submit a request for a Part D coverage Determination.

To start the Part D Coverage Determination process, the Member (or their representative), the doctor or other prescriber should contact Member Services using one of the methods below:

Call Member Services at 1.833.276.8306
TTY/TDD: 711
Fax request to: 855.688.8552 Mail request to:
PO Box 1039
Appleton, WI 54912-1039

How We Process Coverage Determination Pharmacy Requests

For requests for benefits that do not involve exceptions, Community Health Choice must provide notice of its decision within 24 hours after receiving an expedited request or 72 hours after receiving a standard request. The initial notice may be provided orally as long as a written follow-up notice is mailed to the Member within three calendar days of the oral notification.

For requests for benefits that involve exceptions, the adjudication time frames do not begin until the doctor/prescriber submits his or her supporting statement to Community Health Choice.

For payment requests, including payment requests that involve exceptions, Community Health Choice must provide written notice of its decision (and make payment when appropriate) within 14 calendar days after receiving a request.

If the coverage determination is unfavorable, the decision will contain the information needed to file a request for redetermination with Community Health Choice.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Community Health Choice reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment.

Call Navitus at 1.877.866.276.3877 for information about DME and other covered products commonly found in a pharmacy.

Eligibility

Community Health Choice currently offers an HMO D-SNP for individuals who meet the following requirements and may enroll in the plan:

- Entitled to Medicare Part A
- Enrolled in Medicare Part B
- Reside in the Community service area, and
- Eligible for Texas Medicaid categories: QMB or QMB Plus

Individuals must complete an application to enroll and be accepted by Medicare (CMS).

Community Health Choice (HMO D-SNP) service area includes the following counties in Texas:

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

Verifying Member Enrollment in Community Health Choice (HMO D-SNP) Plan

Individuals submit an application to enroll in the plan, and that enrollment must be approved by Medicare. Members will receive a separate Community Health Choice (HMO D-SNP) ID card.

However, having a card does not guarantee Member has current Community Health Choice (HMO D-SNP) coverage. Providers should verify the Member's eligibility for the date of service prior to services being rendered by calling Community Health Choice Medicare Provider Services.

Important: Members can request a Community Health Choice (HMO D-SNP) ID card by calling 1.833.276.8306.

Verifying Community Health Choice Member Eligibility

All Community Health Choice (HMO D-SNP) Members are issued a Member ID card for their Medicare Advantage plan. These individuals will also have a Medicare card and a Texas Medicaid ID card if they are eligible for Medicaid.

When verifying Community Health Choice Member eligibility, ask for the Member's Community Health Choice (HMO D-SNP) Member ID card. Make a copy of both sides of the card for the patient'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 www.CommunityHealthChoice.org/Medicare. Complete the Community Health Choice Secure Access Application to become an authorized user.
- Community Health Choice Medicare Provider Services at 1.833.276.8306. You can check eligibility, benefits and PCP selection. After hours select 24-Hour Nurse Line.
- 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 (HMO D-SNP) ID Card

When a Community Health Choice (HMO D-SNP) Member visits your office, make a copy of both sides of their Member ID card. Please note that although the Community Health Choice Medicare (HMO D-SNP) ID card identifies a Community Health Choice Member, it does not confirm eligibility or guarantee eligibility for benefits coverage or payment.

The Community Health Choice (HMO D-SNP) ID card contains the following information:

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

<div><p>Medicare Advantage</p><p>COMMUNITY HEALTH CHOICE</p><p>Name: Member ID: DOB: Plan Name: Community Health Choice (HMO D-SNP) Effective Date: PCP Name: Medical Group:</p><p>Pharmacy</p><p>BIN: 610602 PCN: NVTD RXGroup: CHCD001 RXID: For more information about your plan, visit our website at CommunityHealthChoice.org/medicare. Contract: H9826 PBP: 001</p></div>	<div><p>Helpful numbers</p><table><tr><td>Member Services 1.833.276.8306 (toll-free) TTY: 711</td><td>Talk to a nurse 24/7 1.833.276.8306</td><td>Dental Service 1.833.276.8306</td></tr><tr><td>Behavioral Health 1.833.276.8306</td><td>Pharmacy 1.833.276.8306</td><td>Vision 1.833.276.8306</td></tr></table><p>In case of emergency, call 9-1-1 or go to the closest emergency room. If you are not sure whether you need to go to the ER, call your Primary Care Provider (PCP), or you may also contact our 24-Hour Nurse Advice Line. After treatment, call your PCP within 24 hours or as soon as possible.</p><p>Provider Services</p><p>Eligibility, authorizations, benefits and claims: Provider.CommunityHealthChoice.org 713.295.5007</p><p>Pharmacy Help Desk: 1.866.270.3877</p><p>Send claims to: Community Health Choice Texas, Inc. P.O. Box 301404 Houston, TX 77230</p><p>Electronic claims: Payor ID 48145</p></div>	Member Services 1.833.276.8306 (toll-free) TTY: 711	Talk to a nurse 24/7 1.833.276.8306	Dental Service 1.833.276.8306	Behavioral Health 1.833.276.8306	Pharmacy 1.833.276.8306	Vision 1.833.276.8306
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Behavioral Health 1.833.276.8306	Pharmacy 1.833.276.8306	Vision 1.833.276.8306					

Enrollment in Community Health Choice (HMO D-SNP)

Individuals must submit an enrollment application and be approved by Medicare to become a Member of Community

Health Choice (HMO D-SNP). Members ARE NOT enrolled automatically.

Members may enroll during their initial election period based on their Medicare entitlement. They can enroll or make changes during annual election period (AEP) October 15 through December 7 and during certain special election periods. For example, Members who have Medicaid/Low Income Subsidy (LIS) can make changes once per calendar quarter during the first nine months of the year. Members who gain, lose or have a change in their Dual or LIS-eligibility status can make an election within three months of the change or notification of the change, whichever is later.

Disenrollment from Community Health Choice (HMO D-SNP)

Members enrolled in the Community Health Choice (HMO SNP) plan must maintain a Medicaid eligibility category of **QMB or QMB Plus** or disenrollment may occur. Members may also request disenrollment during AEP and during certain special election periods. For example, Members who have LIS can make changes once per calendar quarter during the first nine months of the year.

Members who gain, lose or have a change in their Dual or LIS-eligibility status may make an election within three months of the change or notification of the change, whichever is later.

Authorization 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 www.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 713.295.5007 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.

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

Authorization Requests

Community Health Choice accepts Community Health Choice's Preferred Prior Authorization Form, as well as the Texas Standard Prior Authorization Form or any other written documentation. Submit requests for authorization via the

Provider Portal or via fax to 713.295.7059. To avoid delays, include supporting documentation and clinical notes to support your request for authorization 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.

Failure to Obtain Prior Authorization

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

Authorization for Out-of-Network Services

A PCP may request authorization for out-of-network services that cannot be provided within the Community Health Choice network. To request an out-of-network authorization, submit an Authorization Form 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.

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.

Continuity of Care – Medicare Members

Members enrolled in a Community Medicare plan may continue services with their pre-enrollment Providers and access existing service authorizations at the time of enrollment for up to 90 days. Continuity of care for pregnant women described above also applies to Medicare Members.

Community evaluates and ensures continuity of care when a Member's PCP or specialist terminates from the plan. When possible, Community authorizes continued care with the Provider for the completion of treatment or until the Member can be safely transitioned to a contracted Provider. Such authorization may not be possible if the Provider has died, retired, lost medical license, received Medicare or Medicaid sanctions or has moved outside the service area.

Member Moves Out of Service Area

Community 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 713.295.5007 along with Social Security at 1.800.772.1213.

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.

Case Management

All Community Members enrolled in the Community Health Choice (HMO D-SNP) are enrolled in case management.

Community performs a Health Risk Assessment within 90 days of enrollment, annually thereafter, and off cycle when the Member experiences a change such as a new diagnosis, an unplanned admission or a social change including loss of caregiver or loss of housing. The Health Risk Assessment is used to determine the Member's risk level and Individualized Care Plan (ICP).

The ICP is composed of problems identified in the assessment process, goals related to each problem, barriers to achieving the goals, and specific interventions to mitigate the barriers. Case managers are registered nurses and licensed behavioral health clinicians, assigned based on the Member's primary needs and concerns. The case manager develops a preliminary care plan, based on the health risk assessment, and selects the Interdisciplinary Care Team (ICT) with the Member.

The ICT includes the case manager, the Member, and the PCP. Additional Community staff such as a social worker or a pharmacist may be added to the ICT. A specialist may be added to the ICT while the Member is under treatment. The Member may request ICT Members such as a family member, caregiver, friend, neighbor, clergy or other individual who supports the Member with medical decisions or carrying out a treatment plan. The ICT reviews and approves the Individualized Care Plan and makes updates when indicated.

The case manager distributes the care plan initially and when revised to ICT Members and schedules ICT meetings. When PCPs or specialty Providers are not able to attend ICT meetings, the case manager will seek input regarding the care plan prior to the meeting.

Providers may contact our Care Management department at 832.CHC.CARE (832.242.2273) or 1.888.760.2600.

Quality Management

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 upon the outcomes. This includes but is not limited to the following areas:

- Health care access
- Health care delivery
- Contracting and contract administration
- Provider credentialing
- Peer review
- Customer service and satisfaction
- Provider service and satisfaction
- Risk minimization
- Utilization management and 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 Board of Directors (BOD) meetings. The Quality Optimization Committee also tracks and trends quality metrics throughout the year and reports trends and action plans to the Executive Quality Committee.

Community Health Choice's annual QI Work Plan identifies and assures completion of planned QI activities for each year, including those specifically related to the Model of Care (MOC) and the unique healthcare needs of the D-SNP population. It includes specific performance measures, which include time frames for achieving the desired outcomes. Performance is measured to evaluate the ongoing effectiveness and the reporting timeline unique to each measure.

Measures and benchmarks are reviewed annually by the vice president of Medical Affairs and Executive Quality Committee for continued suitability, as well as the development of the Work Plan. Measurements for the Community Health Choice (HMO D-SNP) population include categories of Access, Affordability, Coordination of Care, Transition in Care, Utilization Measures for Preventive Health, and Utilization Measures for Chronic Conditions. The plan identifies the following key elements.

- General and MOC-specific QI and healthcare management activities for the coming year, including goals, objectives, scope, and planned monitoring of new and previously identified issues
- Measurable objectives for each activity scheduled, including the responsible party, time frames for measurement and remeasurement, and measurable goals, to determine if the desired outcomes have been achieved
- Schedule for reporting to the QI committees and BOD
- Schedule for formal annual evaluation of the QI Program, including the MOC evaluation

After input and approval by the subcommittees, the plan is submitted to the EQC for additional recommendations and approval. This includes the determination of the remeasurement period if the goal was not met. The Work Plan changes throughout the year as new issues are identified, and results of measurement activities determine whether goals are met or if remeasurement needs to occur for those activities related to the Community Health Choice (HMO D-SNP) Program.

Quality Improvement Committees

The Executive Quality Committee is established by the Board of Directors as part of the Quality Management, Performance Improvement, and Compliance programs. The Executive Quality Committee is designed as the focal point of management efforts to oversee Community Health Choice (HMO D-SNP) and its employees with legal, regulatory and contractual requirements applicable to the products offered by Community Health Choice, and policies and procedures. Members of Executive Quality Committee include all Members of the executive management team, including the president and CEO (Chair), chief operating officer, all senior vice presidents, and vice presidents.

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 Improvement Projects

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

- Improve 7- and 30-day follow-up appointments after hospitalization for mental illness
- Improve Immunization rates for flu and pneumococcal
- Improve diabetic measures for Members with diagnosis of diabetes (A1C >7.5 and eye exam)
- Follow-up after ER visit for Members with multiple chronic conditions

Community has designated improving access to ambulatory follow-up post hospitalization for mental illness as a Quality improvement Project that addresses consumer safety for all lines of business, including the Community Health Choice (HMO D- SNP) population.

Care Transitions

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

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

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

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

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

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

- Provides and/or confirms education received regarding the Member's condition, the warning signs of complications, and all instructions in the discharge and transition plan, as applicable
- Conducts medication reviews and reconciliations
- Updates the ICP to reflect the transition plan and ensures and/or confirms that the Member understands and agrees to the services
- Ensures prior authorization reviews are conducted to avoid any delays in transition
- Confirms follow-up services and appointments are made and the Member attends these with their PCP and/or specialty Providers. This includes ensuring that transportation to his or her medical appointments is arranged.
- Provides assistance in overcoming barriers including all environmental adaptations and equipment and/or technology the Member needs for a successful care setting transition
- Ensures all community supports are in place
- Ensures Providers are fully knowledgeable and prepared to support the Member, including the interface and coordination among clinical services and other supportive services
- Arranges for care conferences with the Interdisciplinary Care Team (ICT) as required
- Ensures appropriate documentation has reached all applicable Providers, including changes to the ICP, and ensures care coordination system records are made regarding the transition.

Special Access Requirements

Interpreter/Translation Services

Some Community Health Choice Members may need help communicating with their Providers. If you are serving a Community Health Choice Member who speaks another language, call Member Services at 713.295.5007 or 1.833.276.8306 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 713.295.5007 or 1.833.276.8306. 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 among Language Line Services, the Member, and the Community Health Choice representative.

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

- Keep your sentences short and concise. The longer and more complex your sentences, the less accurate the interpretation. When possible, avoid use of medical terminology that is unlikely to translate well.
- Ask key questions several different ways. This increases the chance that you are obtaining a response to exactly what you need to know.
- Be sensitive to potential embarrassment or reticence. It is possible that your question or statements were not accurately translated or understood by the Member.
- Ask Members 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 711 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

Through the Interdisciplinary Care Team, 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:

- Community Resource Coordination Groups (CRCGs)
- Texas Department of Assistance and Rehabilitative Services (DARS)
- Home and Community-Based Services (HCS)
- Community Based Alternatives (CBA)
- Day Activity and Health Services
- Deaf/Blind Multiple Disabled Waiver Program
- Housing, Nutrition, and Transportation 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 fourth- to sixth-grade reading level. The guidelines provided for communication with interpreters are also good guidelines for communicating with Members with limited literacy, including 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 preferably should be referred to treatment Providers who speak the Member's language and have an understanding of related cultural issues. In the event that a Member requires a behavioral health Provider, speaks another language or has specific expertise with a specific culture, they may contact Member Services at 713.295.5007 or toll-free at 1.833.276.8606 to receive appropriate referrals.

Network Referrals

Referral to Specialists and Health-Related Services

Referrals are not required in the Community Health Choice (HMO D-SNP) Program, except for the Meal and Transportation benefits. 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 Members in need of hospitalization only to network facilities or contracted hospitals unless:

- Certification for admission to an out-of-network facility or hospital 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 request authorization for medical services, please call 713.295.5007 or fax to 713.295.2284.

To request authorization for behavioral health services, please call 713.295.5007 or fax to 713.576.0931 (outpatient) or 713.576.0932 (inpatient).

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 of this manual.

Disputes Concerning Professional Competence or Conduct

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 Member or Members 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 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, a majority of which must be of the 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, a majority of which must be of the 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 Medicare license, 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.
- OIG/SAM exclusion screening – Whenever a practitioner appears on the exclusion list.
- Preclusion list screening – Whenever a practitioner appears on the Medicare preclusion list.
- 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 Credentialing and Recredentialing

To ensure a quality network of Providers and comply fully with regulatory requirements and internal standards, Community maintains well-defined policies and procedures related to initial credentialing, recredentialing, and ongoing monitoring of its Providers. The initial and recredentialing processes begin with individual Providers completing the Texas Standardized Application using the CAQH Proview repository. Community's Credentialing Department will download a copy of the completed application, with attestation pages signed within 180 days, upon notification from the Contracting Department that a contract has been secured.

All Providers applying to the network must be reviewed and approved by Community's Credentialing Committee prior to providing care to Community's Members and be listed in the Provider Directory or other Member publications.

Institutional (facility) Providers are required to complete Community's Ancillary or Hospital Credentialing Application, as applicable, which may be obtained directly from Community.

The credentialing process typically takes up to 90 days from receipt of a completed application packet.

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 Members 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.

Billing and Claims

Timely Filing

Claims must be filed using the current standard CMS 1500 Form or UB-04 Form. As a Participating Provider, you have agreed to submit all claims within 95 days from the date of service or the time frames as outlined in your Provider agreement with Community.

Out-of-Network Providers must submit Clean Claims to Community no later than 12 months, or 1 calendar year, after the date the services were furnished (42 CFR 424.44 §70.7).

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 Oct. 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 Healthcare Solutions, Inc. (formerly Emdeon; formerly Relay Health)	1.877.469.3263	48145
AVAILITY	1.800.282.4548	48145
Gateway/TriZetto Provider Solutions	1.800.969.3666	48145

Contact your clearinghouse for questions regarding electronic claims submission.

Submitting Claims by Mail

Claims may be submitted by mail to the following address:

**Community Health Choice Attn: Claims
P.O. Box 301404
Houston, TX 77230**

Or by Certified mail to the following address:

**Community Health Choice
4888 Loop Central Drive, Ste.600
Houston, TX 77081**

Claim Format Standards

Standard CMS required data elements can be found in the CMS claims processing manual located at <https://www.cms.gov/manuals/downloads/clm104c12.pdf> and must be present for a claim to be considered a clean claim.

Community Health Choice can pay only claims that are submitted accurately. The Provider is always responsible for accurate claims submissions. While Community Health Choice will make its best effort to inform the Provider of claims errors, the claim accuracy rests solely with the Provider.

Community Health Choice pays clean claims according to contractual requirements and Centers for Medicare and Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Community Health Choice or substantiating documentation, or a particular circumstance requiring special handling or treatment that prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in your Agreement and applicable federal or state law, including lack of required substantiating documentation for Non-Participating Providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of Community Health Choice, the claim is not considered clean.

When submitting a claim, please follow the guidelines below:

- A separate claim must be completed for each Member and each

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

- If your claim is denied because it did not contain critical claims elements that are required for adjudication of clean claims or you did not submit as indicated above, you may submit your corrected electronic or paper claim with the resubmission code 7 in box 22 of the CMS-1500 claim form or in Loop 2300 electronically. You must indicate the original claim number in the Original Reference number field along with the resubmission code. Print "CORRECTED CLAIM" if submitting paper claim.
- This is NOT an appeal. Do not send corrected claims to the Appeals Department. All corrected claims should respond to the error messages as delineated on the EOB. Claims adjudication status is available 30 days after the submission of a clean claim, by mail or 24 hours a day on the Community Health Choice website at CommunityHealthChoice.org/Medicare.
- Corrected claims must be sent within 180 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.

Ordering, Referring, and Prescribing Providers

All Providers who order, refer and prescribe 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/GRP_Providers_FAQs.pdf.

Rendering Provider Requirement

Community Health Choice requires all professional and institutional claims 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.

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

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 programs;
- b) For claims reimbursed at Original Medicare rates, the current Medicare payment methodology and any associated reductions can be applied (see Sequestration below).

Claims Encounter Data

Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your Community Health Choice Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the Provider after coverage and payment have been determined by Community Health Choice. The statement provides a detailed description of how the claim was processed.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Community Health Choice will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the Member may or may not be billed for services denied by Community Health Choice. The Member may not be billed for a covered service when the Provider has not followed the Community Health Choice procedures. In some instances, providing the needed information may reverse the denial (i.e. referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the Member, or the services are not covered, the EOP/RA will alert you to this and you may bill the customer.

Pricing of Inpatient Claims

Unless the contract states otherwise, Community Health Choice will pay inpatient claims under the applicable inpatient MS-DRG. The MS-DRG includes all outpatient services, including observation and emergency room services, furnished to a Member by a hospital during an uninterrupted encounter (no discharge home) on the date of the Member's inpatient admission or immediately preceding the date of a Member's inpatient hospital admission, regardless of the number of uninterrupted days prior to the inpatient admission.

SNF Consolidated Billing

Consolidated Billing Payment for the majority of services to Members in a Medicare-covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment to the SNF. The SNF must bill these bundled services in a consolidated bill. For services subject to consolidated billing (CB) and provided by entities other than the SNF, the entity looks to the SNF for payment and must not bill separately for those services.

CB Resources: For more information, take the SNF CB web-based training course on the Medicare Learning Network® (MLN) Learning Management and Product Ordering System. To help determine how CB applies to specific services, refer to the flow charts in the Skilled Nursing Facility Prospective Payment System educational product.

Processing Hospice Claims

When a Community Health Choice (HMO D-SNP) Member elects hospice care but chooses not to disenroll from Community, the Member is entitled to continue to receive any HMO-DSNP benefits that are not the responsibility of the hospice through Community Health Choice. Under such circumstances, the premium Community Health Choice receives from the Centers for Medicare and Medicaid Services (CMS) is adjusted to hospice status. As of the day the Member is certified as hospice, the financial responsibility for that Member shifts from Community Health Choice to Original Medicare. During a hospice election, Original Medicare covers all Medicare-covered services rendered with cost sharing of Original Medicare. Community Health Choice will remain financially responsible for any benefits above Original Medicare benefits that are non-hospice related. Non-Medicare covered services, such as vision eyewear allowable, prescription drug claims, and medical visit transportation will remain the responsibility of Community Health Choice. Plan cost sharing will apply to Community Health Choice covered services. If the Member chooses Original Medicare for coverage of covered, non-hospice-care, Original Medicare services, and follows Community Health Choice (HMO D-SNP) requirements, then the Member pays plan cost sharing, and Original Medicare pays the Provider. Community Health Choice will pay the Provider the difference between Original Medicare cost sharing and plan cost

sharing, if applicable. Plan rules must still be followed and apply for both professional and facility charges. A Member who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost sharing. The Member need not communicate to Community in advance his/her choice of where services are obtained. When a Member revokes hospice care, financial responsibility for Medicare-covered services will return to Community Health Choice on the first of the month following the revocation.

The following are the submission guidelines for Community Health Choice (HMO D-SNP) Members enrolled in hospice.

Hospice-Related Services

A Member who elects hospice care but chooses not to disenroll from the health plan is entitled to continue to receive any covered benefits and services other than those that are the responsibility of the hospice. Hospice provides services related to the treatment of the Member's terminal illness and certain physician services (not including treatments).

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

In general, Members will have a zero-cost sharing under the D-SNP when the benefit or service is both a D-SNP and a Medicaid covered benefit or service.

Hospice is not a service covered by Community Health Choice. Services unrelated to the terminal illness are the responsibility of Community Health Choice in accordance with the payment and cost sharing chart above. Submit the claims for hospice services directly to CMS.

Medicare hospices bill the Medicare fee-for-service contractor for Members who have coverage through Medicare Advantage just as they do for customers, or beneficiaries, with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period and is followed by claims with types of bill 81X or 82X. If the Member later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so that the Member's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for Members who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules.

When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked. Community Health Choice (HMO D-SNP) Members that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the Member were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Non-Hospice Services

For Part A services not related to the Member's terminal condition, submit the claim to the fiscal intermediary using the condition code 07.

For Part B services not related to the Member's terminal condition, submit the claim to the Medicare carrier with a "GW" modifier.

For services rendered for the treatment and management of the terminal illness by a non-hospice employed attending physician, submit the claim to the fiscal Intermediary/ Medicare carrier with a "GV" modifier.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320-Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for Members who have elected hospice coverage. The Medicare Managed Care Manual, Chapter 11, Sections 40.2 and 50, and the CMS Program Memorandum AB-03-049 also outline payment responsibility and billing requirements for hospice services. This documentation is also available online at the CMS website: www.cms.gov.

Sequestration

To comply with CMS' various payment methodologies, which includes sequestration, a 2% downward reduction to payments issued to contract and non-contracted Providers will be made. Community Health Choice will adjudicate all claims to align with Medicare's reimbursement policies applicable to Provider payments with the sequestration methodology. Community Health Choice will reduce by 2% payments made to Providers for items and services supplied to Community Health Choice Members.

The Sequestration payment adjustment will be applied at the final payment level after all other edits, rules, and adjustments have been applied.

Claims Audits

With the following exceptions, Community Health Choice must complete all audits of a Provider claim no later than 2 years after receipt of a Clean Claim, regardless of whether the Provider participates in the 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 Member is deemed ineligible

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

If an additional payment is due to the 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, then 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: Payment Refund - HMO D-
SNP P.O. Box 4818
Houston, TX 77210-4818**

Once Community Health Choice team 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. 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 result 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.

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

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 the Member. Neither Community Health Choice nor 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 Member. Authorization is required for post-stabilization services. Emergency service claims are required to follow all claims billing procedures. Claims must identify emergency services with service code 450 or place of service 23.

Out-of-Network Provider Payments

Community Health Choice will be responsible for out-of-network claims for Members with care in progress with non-participating 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 Medicare 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, according to original Medicare reimbursement rates.

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 Medicare 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.

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.

Community Health Choice Claims Payment Options

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

If you have additional questions regarding your payment 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.

Reconsiderations

You have up to 180 days to request reconsideration of a claim. You may request claim reconsideration if you feel your claim was not processed appropriately according to the Community Health Choice claim payment policy or in accordance with your Provider agreement. A claim reconsideration request is appropriate for disputing denials such as coordination of benefits, timely filing, or missing information. Payment retractions and underpayments/overpayments, as well as coding disputes, should also be addressed through the claim reconsideration process. Community Health Choice will review your request, as well as your Provider record, to determine if your claim was paid correctly.

Special Considerations for Dual Eligible Members

Providers should be aware that certain billing prohibitions apply to dual eligible Members whom you serve. Federal law (Sections [1902\(n\)\(3\)\(B\)](#) and [1866\(a\)\(1\)\(A\)](#) of the Act, as modified by Section 4714 of the Balanced Budget Act of 1997) prohibits all Medicare Providers from billing QMB individuals for all Medicare deductibles, coinsurance or copayments. All Medicare and Medicaid payments you receive for furnishing services to a QMB individual are considered payment in full. You are subject to sanctions if you bill a QMB individual for amounts above the sum total of all Medicare and Medicaid payments (even when Medicaid pays nothing). For more information on prohibited billing of QMB individuals, visit [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf) and [SSA.gov/OP_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

In addition, under Section [1848\(g\)\(3\)\(A\)](#) of the Act, all Medicare Providers must accept assignment for Part B services furnished to HMO D-SNP Members. Assignment means that the Medicare-allowed amount (Physician Fee Schedule amount) constitutes payment in full for all Part B-covered services provided to Members.

Provider Payment Disputes

Contracted Providers do NOT have payment appeal rights. Contracted Provider may file a dispute as outlined below.

Claims Questions/Status

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

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

Contact Provider Hotline during regular business hours:

Local: 713.295.5007 or Toll-Free: 1.833.276.8306

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

<ul style="list-style-type: none">• Name of the Provider• Name of physician rendering the service• Provider NPI number• Date(s) of service	<ul style="list-style-type: none">• Provider Tax ID number• Amount of claim• Member ID number and/or name• Exact problem with claim
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Provider Payment Dispute

Community Health Choice offers Providers a payment dispute resolution process. A payment dispute 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 on time
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a Provider

- Inappropriate or unapproved referrals initiated by Providers (i.e., a Provider payment dispute may arise if a Provider was required to get authorization for a service, did not request the authorization, provided the service, and then submitted the claim)
- Provider medical dispute without the Member's consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

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

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

To submit a payment dispute, please send it to:

**Community Health Choice
Attn: Claims-Provider Payment
Dispute 4888 Loop Central Drive,
Ste.600 Houston, TX 77081**

A network Provider should file a payment dispute within 180 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 dispute should include an explanation of what is being disputed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include the following:

- 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, call log record with the date and name of Community Health Choice person 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 payment dispute, we recommend Providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications, at least until the dispute is resolved.

Community Health Choice will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute 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 dispute. An EOP is used to notify Providers of overturned denied claims or additional payments. An upheld denied claim receives a payment dispute determination letter. The determination letter includes the following:

- A statement of the Provider's dispute
- 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

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 Member 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 Community Health Choice (HMO D-SNP) Program as being reasonable and medically necessary for my care. I understand that Community Health Choice 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 Community Health Choice (HMO D-SNP) no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Community Health Choice determina la necesidad médica de los servicios o de las provisiones que el miembro 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 HMO D-SNP 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

Provider Complaints and Appeals

Provider Complaints Process

“Complaint” means an expression of dissatisfaction expressed by a Complainant, orally or in writing to Community Health Choice, about any matter related to Community Health Choice other than an Action (see definition below). 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, and 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 Community Health Choice 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 Drive, Ste.600
Houston, TX 77081
Phone: 713-295-5007
Fax: 713.295.7036**

Email: ServiceImprovement@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 CMS

After a Provider has exhausted the complaint process with Community Health Choice, a Provider has the right to file a complaint with CMS by calling 1.800.MEDICARE.

Provider Appeals Process

Key Terms to Understand

- **“Appeal”** means the formal process by which a Member, a Member’s representative, or a Provider requests a review of a Community Health Choice’s adverse determination for a request for service or payment.
- **“Action”** is: 1.) the denial or limited authorization of a requested 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 timeframes of its contract with HHSC and CMS. 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 a Level 1 appeal of an adverse pre-service determination orally or in writing within 60 calendar days of the date of Community Health Choice’s written notification of an adverse pre-service determination. Contracted

Providers cannot submit an appeal request for denied claims.

Community Health Choice
Attn: Medical Appeals
4888 Loop Central Drive, Ste.600
Phone: 713.295.5007
Toll-Free: 1.833.276.8306
Fax: 713.295.7033

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

Community Health Choice will accept oral request for expedited appeal only. For Standard appeals, please submit a written request.

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 Member or a person acting on the Member's behalf and the Provider. The letter will contain:

- a statement of the specific medical, dental or contractual reasons for the resolution;
- the clinical basis for the decision;
- a description of or the source of the screening criteria that were utilized in making the determination;
- the professional specialty of the physician who made the determination; and
- procedures for filing a complaint

If Community Health Choice's initial decision is upheld during the Level 1 Part C appeal, the case file will be forwarded to Independent Review Entity (IRE) for Level 2 Appeal review.

Expedited Appeals Procedures for Medical Necessity

You have the right to ask for an expedited appeal for a denial of service if you feel the Member'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 health care Provider review the appeal. This health care Provider will be someone who has not previously reviewed the case and is of the same or a similar specialty as the 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 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.

Member Complaints and Appeals

Member Complaint Process

How to File a Complaint

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

**Community Health Choice
Service Improvement
4888 Loop Central Drive, Ste.600
Houston, TX 77081
Fax: 713.295.7036
Email: ServiceImprovement@CommunityHealthChoice.org**

Or by calling Community Health Choice at 713-295-5007 or toll-free at 1.833.276.8306.

Once a Member has gone through the Community Health Choice Complaint process, the Member can complain to CMS, by calling toll-free at 1.800.Medicare (1.800.633.4227), TTY/TTD 1.877.486.2048 or by completing an online form at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Members can also complain to Texas Health and Human Services at 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 should be described.

Requirements and Time Frames for Filing a Complaint

Members, or their representatives, may file a complaint at any time but no later than 60 calendar days from the date of the incident/issue. Community Health Choice will send the complainant a written acknowledgement within five days of the date of receipt of the complaint. 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 713.295.5007 or 1.833.276.8306, and a Community Health Choice Member Advocate will assist them.

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 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 in writing (expedited appeals may be filed orally by calling the phone number listed below).

Member Appeal Process

How to File an Appeal

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

**Community Health Choice
Member Appeals
Coordinator 4888 Loop Central
Drive, Ste.600 Houston, TX
77081
Phone: 713.295.5007 or 1.833.276.8306
Fax: 713.295.7033**

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

Community Health Choice will send the requestor a written acknowledgement within five days of the receipt of an appeal. 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, list 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 that 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 pre-service appeal is denied?

If Community Health Choices denies an appeal for a service, we will forward the appeal case file to an Independent Review Entity (IRE) for Level 2 appeal review. Community Health Choices will also send the Member a denial notice within 30 days of the receipt of a Level 1 appeal request. The denial notice will contain information about the case being forwarded to IRE.

When can a Member request an appeal handled by an Administrative Law Judge or attorney adjudicator?

For this level of appeal, please refer to the Member Explanation of Coverage (EOC) on our Community Health Choice website.

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
Medical Appeals Department
4888 Loop Central Drive, Ste.600
Houston, TX 77081
Phone: 713.295.5007 or 1.833.276.8306
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 713.295.5007 or 1.833.276.8306. 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 make its determination of an expedited appeal within 72 hours of the receipt of the request. 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 taking an extension.

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.

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

General Obligation to Prevent, Detect, and Deter Fraud, Waste, and Abuse

As a recipient of funds from state and federally sponsored health care programs, Community Health Choice has a duty to help prevent, detect, and deter fraud, waste, and abuse. Community Health Choice is committed to detecting, mitigating, and preventing fraud, waste, and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each Provider is required to adopt Community Health Choice policies on detecting, preventing, and mitigating fraud, waste, and abuse in all the federally and state funded healthcare programs in which Community Health Choice participates.

The Community Health Choice policy on fraud, waste, and abuse prevention and detection is part of the Community Health Choice Compliance Program. Electronic copies of this policy and Community Health Choice Code of C can be found on the website at www.communityhealthchoice.org/.

Community Health Choice maintains several ways to report suspected fraud, waste, and abuse. As an HMO D-SNP Provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste, and abuse. These reports can be made by contacting:

Community Health Choice's Compliance Department at 1.877.888.0002; or

CMS at www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html.

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Community Health Choice fraud, waste, and abuse policies and distribute them to any staff members or contractors who work with Community Health Choice. If you have questions or would like more details concerning the Community Health Choice fraud, waste, and abuse detection, prevention, and mitigation program, please contact the Community Health Choice Chief Compliance Officer.

Importance of Detecting, Deterring, and Preventing Fraud, Waste, and Abuse

Healthcare fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. In this section, Community Health Choice educates Providers on how to help prevent Member and Provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste, and abuse have been identified, including the following:

Provider fraud, waste, and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records, and billed according to American Medical Association guidelines.

Member fraud, waste, and abuse

Benefit sharing

- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste, and abuse, Providers can educate Members about these types of fraud and the penalties levied. Also, spending time with Members and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent Member fraud is as simple as reviewing the Medicare Member ID card. It is the first line of defense against fraud. Community Health Choice may not accept responsibility for the costs incurred by Providers rendering services to a patient who is not a Community Health Choice Member, even if that patient presents a Medicare Member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage Members to protect their cards as they would a credit card or cash, always carry their Community Health Choice Member ID card, and report any lost or stolen cards to Community Health Choice as soon as possible.

Community Health Choice believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste, and abuse and working with Members to protect their Community Health Choice ID card can help prevent fraud, waste, and abuse. Community Health Choice encourages its Members and Providers to report any suspected instance of fraud, waste, and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and Community Health Choice will make every effort to maintain anonymity and confidentiality.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum Bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

Community Health Choice strives to ensure both Community Health Choice and contracted participating Providers conduct business in a manner that safeguards Member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the HIPAA privacy regulations.

Community Health Choice recognizes its responsibility under the HIPAA privacy regulations to request only the minimum necessary Member information from Providers to accomplish the intended purpose. Conversely, Providers should only request the minimum necessary Member information required to accomplish the intended purpose when contacting Community Health Choice.

However, please note the privacy regulations allow the transfer or sharing of Member information, which may be requested by Community Health Choice to conduct business and make decisions about care such as a Member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or healthcare operations.

- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need Member information to perform their jobs. When faxing information to Community Health Choice, verify the receiving fax number is correct, notify the appropriate staff at Community Health Choice, and verify the fax was appropriately received.
- Email (unless encrypted) should not be used to transfer files containing Member information to Community Health Choice (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Community Health Choice.
- The Community Health Choice voicemail system is secure and password protected. When leaving messages for Community Health Choice associates, Providers should only leave the minimum amount of Member information required to accomplish the intended purpose.
- When contacting Community Health Choice, Providers should be prepared to verify their name, address, and tax identification number or national Provider identifier number.

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

Let us know if you think a doctor, dentist, 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 ID card
- Using someone else's ID card

- 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;
- Call the Medicare fraud tip line at 1.800.HHS.TIPS (1.800.447.8477)
- TTY 1.800.377.4950
- Email up to 10 pages describing the incident to HHSTips@oig.hhs.gov; or
- You can report directly to Community Health Choice:

**Community Health Choice Chief
Compliance Officer
4888 Loop Central Drive, Ste.600
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 o 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 Health Care 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 Drive, Ste.600
Houston, TX 77081**

Reporting Abuse, Neglect or Exploitation (ANE)

Report suspected Abuse, Neglect, and Exploitation

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

Report to Department of Aging and Disability Services (DADS) at 1.800.647.7418 if the victim is an adult or child who resides in or receives services from:

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

Report to the Department of Family and Protective Services (DFPS) at 1.800.252.5400, or, in non-emergency situations, online at

www.txabusehotline.org if the victim is one of the following:

- An adult who is elderly or has a disability receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following Providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), local mental health authority (LMHAs), community center or behavioral 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

Report to Local Law Enforcement:

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

Model of Care Training

Community Health Choice's Medicare Dual Special Needs Plan (HMO D-SNP) is a CMS-authorized program for people eligible for both Medicare and Medicaid. The Community Health Choice (HMO D-SNP) provides Medicare benefits through a managed Model of Care that employs Member assessment, stratification, individualized care planning, and protocols for Care Transitions. An Interdisciplinary Care Team (ICT) is core to the program's purpose of achieving integrated care and quality outcomes.

Community Health Choice (HMO D-SNP) eligible Members have a higher disease burden, more behavioral health comorbidities, and more social factors with adverse effect on health than the general population.

Community Health Choice will use Interdisciplinary Care Teams (ICTs) to develop each Member's individualized care plan. An ICT is composed of knowledgeable, licensed, and (as appropriate) credentialed individuals involved with the care of the Member, based on the needs of the Member.

The Community Health Choice Case Manager leads the ICT and is responsible for organizing the ICT in response to:

- Member or Provider requests
- Utilization or changes in Member's clinical condition or social situation or medical, nursing facility, and Behavioral Health assessments

The PCP is always a Member of the ICT. The Member, the center of the care- planning process, may choose to include family or caregivers and other clinical or non-clinical people who assist with decision-making or complying with treatment plans.

Possible ICT Members in addition to PCP and Community Health Choice Case Manager include the following:

- Member/caregiver/authorized representative/conservator
- Specialist, behavioral health Provider
- County social worker
- Home health Provider
- Member's neighbor, friend, advocate or clergy with approval from Member

The ICT meets at least annually in a location convenient for the ICT Members, frequently by phone.

Community Health Choice RNs conduct a Health Risk Assessment (HRA) with each Member within 90 days of enrollment and at least annually. The HRA assesses the Member's medical, behavioral, social, cognitive, and functional status. Members may request an HRA at any time.

The HRA is the basis for an Individualized Care Plan (ICP), which has **essential components**:

- The Member's self-management goals and objectives.

*The D-SNP population has significant healthcare challenges, but a segment of the population is deemed **Most Vulnerable Members**:*

1. Homeless
2. Super elderly (> 80 years of age) isolated, mobility issues, and/or dementia
3. Serious mental illness (based on diagnostic codes)
 - a. Multiple hospitalizations (acute care or behavioral health facility) – 3 hospitalizations in 3 months or a readmission within 7 days
 - b. Multiple ED visits (>3 ED visits/rolling 3 months)
 - c. Any encounter with law enforcement
4. Living in a rural area with serious co- morbidities
 - a. Missing 2 out of 3 medical appointments in 3 months or known to not have a relationship with a PCP
 - b. Known lack of transportation
 - c. Has 3 or more chronic medical diseases with known morbidity and mortality
5. Significant medical issues such as late stage III-IV cancer, spinal cord,

Clinical Practice Guidelines (CPGs)

Community Health Choice develops or adopts medical and behavioral health CPGs that are relevant to the HMO D-SNP population and promotes the CPGs to the network. CPGs are posted on the Community Health Choice Provider portal. The use of clinical practice guidelines and nationally recognized protocols may need to be modified or are not appropriate for some vulnerable HMO D-SNP Members due to multiple chronic conditions or other

- The Member's personal healthcare preferences.
- Identification of goals (met or not met).
- Barriers to meeting goals.
- If the Member's goals are not met, the process for reassessing the current ICP and determining the appropriate alternative actions.
- Description of the role of the Member's caregiver.

Care Transitions

Community Health Choice uses care transition protocols to maintain continuity of care for HMO D-SNP Members. A care transition is the movement of a Member from one care setting to another as the Member's health status changes. Care settings are a private home, home with home health care, acute care or Long-Term Acute Care (LTAC) Hospital, Skilled Nursing Facility or other facility settings such as Nursing Home or Board & Care.

The Community Health Choice Case Manager is the Member's single point-of-contact through transitions who has ongoing contact with the Member and/or caregiver to ensure that any questions or concerns about the transition process are addressed timely and thoroughly. The case manager, with the ICT, ensures information regarding the Member's care plan and treatment protocols are shared with treating Providers. Records and care plan are properly updated. The Case Manager facilitates communication and referrals to support changes in treatment and follow up on scheduled services as required for successful care transitions.

The Community Health Choice (HMO D-SNP) Provider Network

Community Health Choice's network is designed to meet the needs of D-SNP Members, including primary care, medical specialists, behavioral health clinicians, and facilities. Out of network Providers are approved through the UM process when the Member's needs cannot be met through contracted Providers. A pharmacy benefits manager and pharmacy network are contracted.

HMO D-SNP network Providers and Vendors are required to complete Model of Care training when joining the network and annually thereafter.

Providers must notify Community Health Choice of practice changes in a timely manner to ensure an accurate Provider directory.

Quality Program and Performance Improvement

Community Health Choice maintains a robust quality program to monitor key aspects of Member outcomes and experience, and to continuously evaluate and improve the Model of Care.