



COMMUNITY FIRST
HEALTH PLANS



Children's Health Insurance Program (CHIP)

**Service Area includes:
Atascosa, Bandera, Bexar, Comal, Guadalupe,
Kendall, Medina, and Wilson Counties**

Provider Manual

**Provider Services Phone Numbers
800-434-2347
(210)358-6030**

**Website7
WWW.CFHP.COM**

TABLE OF CONTENTS

| | | |
|-------------|---|-----------|
| I. | INTRODUCTION..... | 7 |
| A. | Background and Objectives | 7 |
| B. | Quick Reference Phone List..... | 7 |
| C. | Role of the Primary Care Physician..... | 8 |
| D. | Role of the Specialty Care Provider | 9 |
| E. | Specialty Physicians Caring for Members with Disabilities | 9 |
| F. | Provider Network Limitations..... | 10 |
| G. | Provider Marketing Guidelines..... | 10 |
| II. | CORRDINATION WITH NON-CHIP COVERED SERVICES..... | 11 |
| A. | Coordination with Public Health Services..... | 11 |
| III. | CHIP COVERED SERVICES..... | 12 |
| A. | CHIP Schedule of Benefits | 12 |
| B. | CHIP Program Exclusions from Covered Services | 19 |
| IV. | BEHAVIORAL HEALTH | 25 |
| A. | Behavioral Health | 25 |
| B. | PCP Requirements for Behavioral Health | 30 |
| C. | Behavioral Health Services | 30 |
| V. | QUALITY MANAGEMENT IMPROVEMENT PROGRAM | 32 |
| A. | Introduction..... | 32 |
| B. | General Requirements of the QMIP | 32 |
| C. | Delegation of QMIP Activities | 34 |
| D. | Credentialing and Recredentialing | 34 |
| VI. | PROVIDER RESPONSIBILITES | 34 |
| A. | PCP (Medical Home) Responsibilities | 34 |
| B. | Access and Availability Standards | 35 |
| C. | Plan Termination | 38 |
| D. | Members Right to Designate an OB/GYN..... | 39 |
| E. | Referral to Specialists and Health Related Services..... | 39 |
| F. | Specialty Provider Responsibilities | 39 |
| G. | Verifying Member Eligibility and Benefits | 40 |
| H. | Costs of Non-Covered Benefits | 41 |
| I. | Member’s Continuity of Care..... | 41 |
| J. | Transition of Care..... | 41 |
| K. | Medical Records Standards | 42 |
| L. | Amendment of Medical Records | 42 |
| M. | Access to Medical Records | 43 |
| N. | Coordination with Texas Department of Family and Protective Services | 44 |
| O. | Reporting of Suspected Sexual Abuse or Neglect of a Child | 44 |
| P. | Justification for Out of Network Referrals | 44 |

| | | |
|--------------|--|-----------|
| VII. | ROUTINE, URGENT AND EMERGENCY SERVICES | 44 |
| A. | Emergency Care | 44 |
| B. | Urgent Care | 45 |
| C. | Emergency and Non-Emergency Transportation | 46 |
| D. | Emergency Prescription Supply | 46 |
| E. | State Fair Hearing Information | 47 |
| VIII. | CHIP PROVIDER COMPLAINTS AND APPEALS | 47 |
| A. | Provider Complaint and Appeal Process | 47 |
| IX. | CHIP MEMBER COMPLAINTS AND APPEALS | 49 |
| A. | Member Complaint Process | 49 |
| B. | Member Appeal Process | 50 |
| C. | Expedited Community First Member Appeal | 50 |
| D. | Member Independent Review Organization (IRO) Process | 51 |
| X. | CHIP MEMBER ELIGIBILITY AND ADDED BENEFITS | 52 |
| A. | Member Eligibility | 52 |
| B. | Pregnancy and CHIP Eligibility | 52 |
| C. | Span of Eligibility | 53 |
| D. | Identifying CHIP Members | 54 |
| XI. | MEMBER RIGHTS AND RESPONSIBILITIES | 54 |
| A. | Member Rights and Responsibilities | 54 |
| XII. | LEGAL AND REGULATORY GUIDELINES | 57 |
| A. | Law, Rules and Regulations | 57 |
| B. | Liability | 59 |
| C. | Member Communications | 59 |
| D. | Provider Requirements, CHIP Arrangements, TPI and NPI | 59 |
| E. | Professional Conduct | 59 |
| F. | Terminations for Gifts or Gratuities | 60 |
| G. | Professional Liability Insurance | 60 |
| H. | On-Site Reviews | 60 |
| I. | Practice Guideline Development | 61 |
| J. | Pre-existing Conditions | 62 |
| K. | Confidentiality | 62 |
| L. | Fraud Reporting | 62 |
| M. | Special Investigation Unit | 66 |
| N. | Fraud and Abuse Compliance Program | 67 |
| O. | Audit or Investigation | 67 |

| | |
|---|-----------|
| XIII. CHIP ENCOUNTER DATA BILLING AND CLAIMS ADMINISTRATION..... | 68 |
| A. Where to Send Claim/Encounter Data | 68 |
| B. Claim Forms to Use | 69 |
| C. Claims Submission | 72 |
| D. Electronic Data Interface (EDI) | 72 |
| E. Services Included in Monthly Capitation | 73 |
| F. Emergency Services Claims | 74 |
| G. Cost Sharing Schedule..... | 74 |
| H. Billing Members..... | 74 |
| I. Time Limits for Submission of Claims, Encounter Data and Appeals..... | 75 |
| J. Negative Balances | 77 |
| K. Coordination of Benefits | 77 |
| L. Third Party Recovery | 77 |
| M. Explanation of Payment (EOP) | 77 |
| N. EOP, Duplicate Checks and Cancelled Check Requests..... | 78 |
| O. IntelliClaim..... | 79 |
| XIV. CHIP MEMBER ENROLLMENT AND DIS-ENROLLMENT | 79 |
| A. Enrollment..... | 79 |
| B. Re-Enrollment..... | 80 |
| C. Dis-Enrollment | 80 |
| D. Plan Changes..... | 82 |
| XV. CHIP SPECIAL ACCESS REQUIREMENTS..... | 82 |
| A. Interpreter/Translation Services..... | 82 |
| B. Community First/Provider Coordination..... | 82 |
| C. Reading/Grade Level Consideration..... | 82 |
| D. Cultural Sensitivity | 83 |
| XVI. UTILIZATION MANAGEMENT | 83 |
| A. Overview | 83 |
| B. Pre-Authorization | 83 |
| C. Referrals | 85 |
| D. Self-Referrals..... | 85 |
| E. Private Pay Patients..... | 86 |
| F. Quality Management Improvement Program/Behavioral Health Medical Records..... | 86 |
| XVII. CASE MANAGEMENT..... | 86 |
| A. Introduction..... | 86 |
| B. Functions of the Case Management Program..... | 87 |
| C. Case Management for Children with Complex Special Health Care Needs .. | 88 |
| XVIII. HEALTH PROMOTION AND WELLNESS..... | 89 |
| A. Provider Referral..... | 89 |
| B. Health Education Services | 90 |

| | | |
|-------------|--|------------|
| XIX. | APPEALS | 96 |
| | A. Adverse Determination..... | 96 |
| | B. Appeals of “For Cause” Termination of HMO Agreement..... | 97 |
| XX. | OTHER | 98 |
| | A. Member Copayments | 98 |
| | B. PCP Requests for Member Transfer | 98 |
| | C. Member Requests for PCP Change..... | 99 |
| | D. Continuity of Care | 99 |
| | E. Transition of Care..... | 99 |
| | F. Specialist as PCP | 99 |
| | G. Release of Information | 100 |
| | H. Member Privacy..... | 100 |
| | I. PCP Request to Change Panel Status | 100 |
| | J. Vendor Drug Program | 100 |
| | K. Provider Under Investigation | 101 |
| | L. Balance Billing Members | 101 |
| | M. Member Acknowledgement Statement..... | 102 |
| | N. Private Pay Form Agreement | 102 |
| | O. CHIP Vaccine Program..... | 102 |
| | P. STD and HIV Testing and Reporting Procedures..... | 103 |
| | Q. Early Childhood Intervention (ECI) Services..... | 105 |
| | R. Tuberculosis Services Provided by DSHS | 105 |

EXHIBITS

| | |
|-------------------|---|
| Exhibit 1 | Request for Continuity of Care Form |
| Exhibit 2 | Behavioral Health Authorization Request |
| Exhibit 3 | Provider Complaint Form |
| Exhibit 4 | Provider Appeal Form |
| Exhibit 5 | CHIP Identification Card |
| Exhibit 6 | TB Form |
| Exhibit 7 | Provider Office Assessment Tool |
| Exhibit 8 | Physician Medical Record Audit Tool |
| Exhibit 9 | Pediatric Preventive Care Recommendations |
| Exhibit 10 | CMS HCFA 1500 |
| Exhibit 11 | UB-04 |
| Exhibit 12 | CHIP Cost Sharing Schedule |
| Exhibit 13 | Claims Appeal Submission Form |
| Exhibit 14 | Explanation of Payment |
| Exhibit 15 | Authorization List |
| Exhibit 16 | Children with Complex Special Health Care Needs Form |
| Exhibit 17 | Member Education Request Form |
| Exhibit 18 | Provider Request for Transfer |
| Exhibit 19 | Private Pay Agreement |
| Exhibit 20 | Texas Vaccine for Children Forms |
| Exhibit 21 | Texas Referral Authorization Form |
| Exhibit 22 | Member/Client Acknowledgement Statement |

I. INTRODUCTION

A. Background and Objectives of Program

Welcome to the Community First Health Plans, Inc. (Community First) Children's Health Insurance Program (CHIP) Network.

CHIP is a managed care plan for uninsured children in Texas. Our objective is to ensure that CHIP Members access primary care services appropriately and receive services in the most cost-effective setting. Our network comprises physicians, allied and ancillary health care providers, hospitals and other facilities selected to provide quality health care to our CHIP Members. The Primary Care Physician (PCP) is responsible for managing the overall medical care of patients, and coordinating referrals to specialists and inpatient/outpatient facilities. The PCP is a Community First network provider with one of the following specialties: General Practice, Family Practice, Pediatrics or Internal Medicine.

This manual is to assist you and your staff in working with us to deliver quality health care to Community First CHIP Members. It provides information regarding our utilization and quality management programs, preauthorization and referral notification procedures, filing of claims, and our appeal process. We encourage you and your staff to review this manual carefully, and contact your Network Management Representative if you have any questions, comments or concerns. We welcome suggestions for enhancing this manual from you and your staff.

We will mail bulletins to your office to advise you of any changes/updates to this manual. In addition, Community First will publish and distribute a quarterly newsletter to all network providers. The newsletter will include information about Community First services, policies and procedures, and appropriate government statutes and regulations.

Community First has contracted with an interpreter service for any provider office that does not have bilingual employees or sign language interpreters. Services are available for sign language, Spanish, English, and other languages that CHIP Members may speak. The service is accessible 24 hours a day, seven days a week. Providers can use the service during normal business hours by calling our Member Services Department at **210-358-6300**, and after hours by calling **210-358-6300** and you will automatically be transferred to The Nurse Advice Line.

B. Quick Reference Phone List

How to Contact Us

Listed below are important telephone numbers for you to use when you need to reach us:

| | |
|--|----------------------------------|
| From Outside Bexar County | (800)-434-2347 |
| Health Services Management | (210)-358-6050 |
| Preauthorization Fax | (210)-358-6040 |
| Urgent Care (Contact Community First) | (210)-227-2347 |
| After Hours you will be connected to The Nurse Advice Line | |
| Case Management | (210)-358-6100 |
| Member Services | (210)-358-6300 |
| Eligibility/Benefits Verification | |
| Interpreter Services - Sign and language | |
| From outside Bexar County | (800)-434-2347 |
| TDD (for the hearing impaired) | (210)-358-6080 (800)-390-1175 |
| Network Management | (210)-358-6200 |
| Claims Department (General Inquiries) | (210)-358-6200 |
| Nurse Advise Line-After Hours | (210)-358-6000 |
| Preventative Health & Disease Management | (210)-358-6153 |
| Community Outreach Agencies | (210)-358-6153 |

C. Role of the Primary Care Physician

The PCP's play an integral role in helping us meet the objectives of our health plan. Community First places its main focus on the total well being of the CHIP Member while providing a "medical home" where the CHIP Member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. CHIP Member's families are encouraged to become more involved in the health care, and maintenance of the wellness of their children. The PCP is responsible for teaching CHIP Members and the CHIP Members family how to use available health services appropriately.

The PCP will provide preventive health services in accordance with the health plan standards, and related medical policies. They will also coordinate the provision of all covered services to CHIP Members, initiate referrals to network specialty care providers, network facilities and contractors, monitor the CHIP Member's progress, facilitate the CHIP Member's return to the PCP when medically appropriate, and

educate CHIP Members and their families regarding their medical care needs. It is the responsibility of the PCP to contact Community First to verify CHIP Member eligibility and/or obtain authorizations for covered services.

The PCP, along with the Community First case manager, coordinates with community – based services for Early Childhood Intervention (ECI) and multidisciplinary care coordination, as needed to avoid separate and fragmented evaluations and service plans. Referrals to ECI services must occur within 2 days of the identification of an infant or toddler under age 3 with developmental disabilities.

The PCP will need to document the referral to ECI services in the CHIP Member’s medical record. A referral for ECI services, however, is not required. However, an authorization is required for CHIP and other Commercial Services for ECI.

The PCP will provide, or arrange for the provision of covered services and/or telephone consultations during normal office hours, after normal business hours, as well as, on an emergency basis, 24 hours a day, seven days a week. The PCP should educate CHIP Members to seek their services before accessing other health care services, except in emergency situations.

D. Role of the Specialty Care Provider

The specialty care provider is responsible for providing medically necessary services to Community First CHIP Members who have been referred by their PCP for specified treatment or diagnoses. Specialists should always verify the eligibility of the referred CHIP Member prior to rendering services. Specialists requesting services that require authorization must request the authorization from Community First’s Health Services Management Department, prior to rendering services. The Specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP’s and Specialist’s medical records.

E. Specialty Physicians Caring for Members with Disabilities and/or Chronic/Complex Conditions

On an individual case basis, Community First may allow a network specialist currently treating a CHIP Member with disabilities or chronic complex conditions to serve in the capacity of PCP. The network specialist must agree to perform all PCP duties, care coordination and such duties must be within the scope of the participating specialist’s certification. Network specialists wanting to become a PCP for CHIP Members with disabilities or chronic or complex conditions should complete the **Request For Continuity of Care** form (**Exhibit 1**) and submit the form to Community First’s Health Services Management Department for review and approval by Community First’s Medical Director. To obtain further assistance in this process, please contact the Health Services Management Department at **210-358-6050**.

Community First requires all non-Primary Care Physicians who wish to be a Member's PCP to initiate a written request for certification as a PCP and to complete an amendment to their existing Professional Provider Agreement that outlines their duties and responsibilities. The written request must contain the following information:

1. Certification by the non-primary care physician specialist as a PCP.
2. A signed statement by the non-primary care physician specialist that he or she is willing to accept responsibility for the coordination of all the member's health care needs including referrals to other specialists.
3. The signature of the member concurring with the request.

F. Provider Network Limitations

A CHIP Member may select a PCP who is part of a Limited Provider Network (an association of health providers who work together to provide a full range of health care services). If a CHIP Member selects a PCP in a Limited Provider Network, the PCP will arrange for services through a specific group of specialists, hospitals and/or ancillary providers who are part of the PCP's network. In such a case, a CHIP Member may not be allowed to receive services from any physician or health care provider or hospital that are not part of the PCP's network. (excluding Behavioral Health providers) except in the case of an emergency as defined in this Provider Manual (Section XV, Utilization Management, Subsection "E")

G. Provider Marketing Guidelines

1. Provider Agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC/MCO Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).
2. Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Network Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
3. Providers may not promote the selection of specific health plans within the context of the CHIP enrollment process.
4. Health care providers may undertake a variety of activities designed to encourage families to apply to the TexCare. Examples include, but are not limited to:
 - a. Displaying posters, brochures, or other written material

- b. Distributing application booklets to families with uninsured children
 - c. Playing a video that promotes TexCare.
 - d. Informing their patients of the toll-free TexCare hotline
5. Providers may educate their patients about TexCare or CHIP Program specifically.
 6. Providers may not assist families in filling out the health plan selection form.
 7. Providers may not distribute health plan marketing materials in their offices.
 8. Providers may inform their patients regarding the plans in which they participate.
 9. Providers may inform their patients of the benefits, services, and specialty care providers offer through the CHIP plans in which they participate.
 10. At the patients' request, providers may give patients the information necessary to contact a particular health plan.
 11. Providers may distribute or display written health educational materials or health related posters (no larger than 16 x 24) provided it is done for all plans in which the providers participate; these materials may have the health plan's name, logo, and phone number.
 12. Providers may display plan stickers (no larger than 6"x 8") indicating they participate with a particular Health Plan as long as they do not indicate anything more than "health plan is accepted or welcomed here."

II. COORDINATION WITH NON-CHIP COVERED SERVICES (NON-CAPITATED SERVICES)

A. Coordination with Public Health Services

Community First collaborates and coordinates with Texas Agency Administered Programs and Essential Public Health Services for CHIP Members to include:

1. Early Childhood Intervention (ECI)
2. Pregnant Women and Infants Case Management (PWI)
3. Children with Special Health Care Needs (CSHCN) Program

4. School Health and Related Services (SHARS)
5. Vendor Drug Program
6. CHIP Dental Program
7. Mental Health Targeted Case Management
8. Mental Health Rehabilitation
9. Texas Commission for the Blind Case Management
10. Tuberculosis Services Provided by DSHS-approved providers (directly observed therapy and contact investigation)

III. CHIP COVERED SERVICES

A. CHIP Schedule of Benefits

| TYPE OF BENEFIT | DESCRIPTION OF BENEFIT | LIMITATIONS AND/OR EXCLUSIONS | CO-PAY AND/OR DEDUCTIBLE |
|---|---|--|---|
| Inpatient General Acute and Inpatient Rehabilitation Hospital Services | Medically necessary services include, but are not limited to the following: <ul style="list-style-type: none"> ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration | Requires prior authorization for non-Emergency Care and care following stabilization of an Emergency Condition. Requires prior authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. | Schedule A: \$10 inpatient copayment Schedule B: \$25 inpatient copayment Schedule C: \$50 inpatient copayment Schedule D: \$100 inpatient copayment |

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| | <ul style="list-style-type: none"> ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS — designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia associated with dental care ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit | | |
| Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Services | <p>Services include, but not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology | <ul style="list-style-type: none"> • May require prior authorization • and Physician prescription | <p>Applicable level of co-pay applies to prescription drug services Co-pays do not apply to preventive services</p> |

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| | <p>services (technical component)</p> <ul style="list-style-type: none"> • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy. <ul style="list-style-type: none"> • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants <p>Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period</p> | | |
| Physician/Physician Extender Professional Services | <p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to, vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component | May require prior authorization for specialty services | <p>Schedule A: \$3 copayment for office visits.</p> <p>Schedule B: \$5 copayment for office visits.</p> <p>Schedule C: \$7 copayments for office visits.</p> <p>Schedule D: \$10 copayment for office visits.</p> <p>Copayments do not apply to preventive visits; or to prenatal visits after the first visit.</p> |

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| | <p>(in/outpatient) of surgical services, including:</p> <ul style="list-style-type: none"> - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations <ul style="list-style-type: none"> ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation | | |
| <p>Home and Community Health Services</p> | <p>Services provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.,) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide (under the supervision of a R.N.) when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and | <ul style="list-style-type: none"> • Requires prior authorization • and Physician prescription • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker <ul style="list-style-type: none"> • Skilled nursing visits are provided on intermittent level and not intended to provide 24- hour skilled nursing services. <p>Services are not intended to replace 24-hour inpatient or skilled nursing facility services</p> | <p>Schedule A: None</p> <p>Schedule B: None</p> <p>Schedule C: None</p> <p>Schedule D: None</p> |

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| | <p>occupational therapies.</p> <ul style="list-style-type: none"> ▪ Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24 hour skilled nursing services ▪ Services are not intended to replace 24 hour inpatient or skilled nursing facility services | | |
| Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies | <p>Covered Services include DME equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home, including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:</p> <ul style="list-style-type: none"> ▪ Orthotic braces and orthotics ▪ Prosthetic devices such as artificial eyes, limbs, and braces ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Other artificial Implantable devices are covered under Inpatient and Outpatients services and do not count towards the DME 12-month period limit ▪ Hearing aids <p>Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements (See Attachment A)</p> | <ul style="list-style-type: none"> • May require prior authorization and Physician prescription <p>\$20,000 12 month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap)</p> | <p>Schedule A: None</p> <p>Schedule B: None</p> <p>Schedule C: None</p> <p>Schedule D: None</p> |
| Case Management Services for Children with | <p>Case Management Services for Children with Special Health Care Needs (CSHCN)</p> <p>Covered Services are above and</p> | <p>Available to families of children with special health care needs wanting these services.</p> | <p>Schedule A: None</p> <p>Schedule B: None</p> |

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| <p>Complex Special Health Care Needs (CCSHCN)</p> | <p>beyond those normally provided to all Members and include, but are not limited to:</p> <ul style="list-style-type: none"> • Outreach and informing— Includes discussion of Covered Services (including specialty services) with the family, the possibility of the family’s right to select a in-network Specialist Physician as a PCP, out-of-network services applicable to the CHILD’S condition if not available in-network, the availability of enhanced care coordination and community referrals • Enhanced care coordination— Includes responding to a family’s request for coordination activities or suggesting this service to the family where appropriate. Services are delivered at an administrative level and to facilitate overall care. • Intensive case management— Trained case managers (nurses or social workers) who provide case management activities such as intake, assessment of services needed and written documentation of individual plan specifying assistance with accessing services and periodic re-assessment. A PCP or Specialist Physician approves a formal written plan of care. <p>Community referral—HEALTH PLAN works to enlist and establish relationships with community organizations to promote improved referrals and service delivery to increase the health and well being of CHIP Members.</p> | | <p>Schedule C: None Schedule D: None</p> |
| <p>Rehabilitation Services</p> | <p>Services include, but are not limited to, the following: Habilitation (the process of supplying a child with the means to reach are-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but</p> | <p>May require prior authorization and Physician prescription</p> | <p>Schedule A: None Schedule B: None Schedule C: None Schedule D: None</p> |

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| | are not limited to the following: Physical, occupational and speech therapy Developmental assessment | | |
| Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services | HMO cannot require authorization as a condition for payment for conditions or labor and delivery Covered Services include, but are not limited to , the following:: <ul style="list-style-type: none"> ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and Physician services 24 hours a day, 7 days a week, both by in-network and out-of-network Physicians and Providers ▪ Medical screening examination ▪ Stabilization services Access to DSHS designated Level 1 and Level II trauma centers or Hospitals meeting equivalent levels of care for emergency services Emergency ground, air and water transportation Emergency dental services, limited to fractured or dislocated jaw. Traumatic damage to teeth, and removal of cysts. | May require prior authorization for post-stabilization services | Schedule A: Visit Copayment (facility only): \$3 Schedule B: Visit Copayment (facility only): \$5 Schedule C: Visit Copayment (facility only): \$50 Schedule D: Visit Copayment (facility only): \$50 |
| Transplants | Cover Services Include, but are not limited to, the following: Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow transplants and peripheral stem cell transplants, including donor medical expenses. | Requires prior authorization | Schedule A: None Schedule B: None Schedule C: None Schedule D: None |
| Skilled Nursing Facilities (Includes Rehabilitation Hospitals) | Medically necessary services include, but are not limited to, the following: <ul style="list-style-type: none"> • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility | Requires prior authorization and physician prescription 60 days per 12-month period limit | Co-pays do not apply |

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|-----------------------------------|---|--|--|
| Hospice Care Services | Medically necessary hospice services include, but are not limited to: <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment for unrelated conditions is unaffected | May require prior authorization for post-stabilization services | Applicable co-pays apply to emergency room visits (facility only) |
| Chiropractic services | Medically necessary services do not require physician prescription and are limited to spinal subluxation | Does not require authorization for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit) Requires authorization for additional visits. | Applicable level of co-pay applies to office visits billed for refractive exam |
| Tobacco Cessation Programs | Covered up to \$100 for a 12-month period limit for a plan-approved program | May require authorization, May be subject to formulary requirements. Health Plan defines plan-approved program | Co-pays do not apply |
| Vision Benefit | Medically necessary services include: <ul style="list-style-type: none"> • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period | The health plan may reasonably limit the cost of the frames/lenses. <ul style="list-style-type: none"> • May require prior authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye | Applicable level of co-pay applies to office visits billed for refractive exam |

Note: Community First’s responsibilities shown above are subject to contractual requirements between Community First and provider (i.e., **Authorization List (Exhibit 15)** and claim submission requirements) and Member eligibility for CHIP.

B. CHIP Program Exclusions from Covered Services

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or Injury

- Experimental and/or Investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Mechanical organ replacement devices including, but not limited to artificial heart
- Private duty nursing services when performed on an inpatient basis
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Community First
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by Community First except for Emergency Care and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by Community First
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor

- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purpose
- Custodial care (care that assists a CHILD with activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This exclusion does not apply to Hospice Services)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses for transplants
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.

| SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS |
|---------------------------|---------|----------|--|
| Ace Bandages | | X | Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply. |
| Alcohol, rubbing | | X | Over-the-counter supply. |
| Alcohol, swabs (diabetic) | X | | Over-the-counter supply not covered, unless RX provided at time of dispensing. |
| Alcohol, swabs | X | | Covered only when received with IV therapy or central line kits/supplies. |
| Ana Kit Epinephrine | X | | A self-injection kit used by patients highly allergic to bee stings. |
| Arm Sling | X | | Dispensed as part of office visit. |

| SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS |
|---|----------------|-----------------|---|
| Attends (Diapers) | X | | Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan |
| Bandages | | X | |
| Basal Thermometer | | X | Over-the-counter supply. |
| Batteries – initial | X | . | For covered DME items |
| Batteries – replacement | X | | For covered DME when replacement is necessary due to normal use. |
| Betadine | | X | See IV therapy supplies. |
| Books | | X | |
| Clinitest | X | | For monitoring of diabetes. |
| Colostomy Bags | | | See Ostomy Supplies. |
| Communication Devices | | X | |
| Contraceptive Jelly | | X | Over-the-counter supply. Contraceptives are not covered under the plan. |
| Cranial Head Mold | | X | |
| Diabetic Supplies | X | | Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips. |
| Diapers/Incontinent Briefs/Chux | X | | Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan |
| Diaphragm | | X | Contraceptives are not covered under the plan. |
| Diastix | X | | For monitoring diabetes. |
| Diet, Special | | X | |
| Distilled Water | | X | |
| Dressing Supplies/Central Line | X | | Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change. |
| Dressing Supplies/Decubitus | X | | Eligible for coverage only if receiving covered home care for wound care. |
| Dressing Supplies/Peripheral IV Therapy | X | | Eligible for coverage only if receiving home IV therapy. |
| Dressing Supplies/Other | | X | |
| Dust Mask | | X | |
| Ear Molds | X | | Custom made, post inner or middle ear surgery |

| SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS |
|----------------------------|---------|----------|--|
| Electrodes | X | | Eligible for coverage when used with a covered DME. |
| Enema Supplies | | X | Over-the-counter supply. |
| Enteral Nutrition Supplies | X | | Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease |
| Eye Patches | X | | Covered for patients with amblyopia. |
| Formula | | X | <p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product <p>Does not include formula:</p> <ul style="list-style-type: none"> • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p> |

| SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS |
|--|---------|----------|--|
| Gloves | | X | Exception: Central line dressings or wound care provided by home care agency. |
| Hydrogen Peroxide | | X | Over-the-counter supply. |
| Hygiene Items | | X | |
| Incontinent Pads | X | | Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan |
| Insulin Pump (External) Supplies | X | | Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item. |
| Irrigation Sets, Wound Care | X | | Eligible for coverage when used during covered home care for wound care. |
| Irrigation Sets, Urinary | X | | Eligible for coverage for individual with an indwelling urinary catheter. |
| IV Therapy Supplies | X | | Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy. |
| K-Y Jelly | | X | Over-the-counter supply. |
| Lancet Device | X | | Limited to one device only. |
| Lancets | X | | Eligible for individuals with diabetes. |
| Med Ejector | X | | |
| Needles and Syringes/Diabetic | | | See Diabetic Supplies |
| Needles and Syringes/IV and Central Line | | | See IV Therapy and Dressing Supplies/Central Line. |
| Needles and Syringes/Other | X | | Eligible for coverage if a covered IM or SubQ medication is being administered at home. |
| Normal Saline | | | See Saline, Normal |
| Novopen | X | | |
| Ostomy Supplies | X | | Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions. |
| Parenteral Nutrition/Supplies | X | | Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Community First has authorized the parenteral nutrition. |
| Saline, Normal | X | | Eligible for coverage: |

| SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS |
|---|---------|----------|---|
| | | | a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation. |
| Stump Sleeve | X | | |
| Stump Socks | X | | |
| Suction Catheters | X | | |
| Syringes | | | See Needles/Syringes. |
| Tape | | | See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies. |
| Tracheostomy Supplies | X | | Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage. |
| Under Pads | | | See Diapers/Incontinent Briefs/Chux. |
| Unna Boot | X | | Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit. |
| Urinary, External Catheter & Supplies | | X | Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan |
| Urinary, Indwelling Catheter & Supplies | X | | Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed. |
| Urinary, Intermittent | X | | Cover supplies needed for intermittent or straight catheterization. |
| Urine Test Kit | X | | When determined to be medically necessary. |
| Urostomy supplies | | | See Ostomy Supplies. |

IV. BEHAVIORAL HEALTH

- A. Behavioral Health** is a term that includes mental health, psychiatric, marriage and family counseling, addictions treatment and substance abuse. Services are provided by a myriad of providers, including social workers, counselors, psychiatrists, psychologists, neurologists and even family practice physicians. Behavioral Health is considered to be reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder or to maintain or to prevent deterioration of function resulting from the disorder; and provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.

Effective October 1, 2005, inpatient and outpatient behavioral health services for CHIP Members are:

1. Inpatient Mental Health Services

2. Partial Hospitalization Services
3. Intensive Outpatient Services
4. Residential Mental Health Services
5. Outpatient Mental Health Services
6. Inpatient Substance Abuse Treatment Services
7. Outpatient Substance Abuse Treatment Services

Services listed may require prior authorization; see **Behavioral Health Authorization Request (Exhibit 2)**. For eligibility and benefit information/limitations contact Community First Member Service Department 358-6300.

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their record:

- All entries are clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider
- Notations of the beginning and ending session times for counseling and/or each test administered.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
 - a. Name of test(s) (e.g., Wechsler Adult Interference Scale-Revised (WAIS-R), Rorschach, Minnesota Multiphasic Personality Inventory (MMPI))
 - b. Background and history of client and reason for testing.
 - c. Behavioral observations during the session.
 - d. Narrative description of the counseling session or test findings
 - e. Diagnosis (symptoms, impressions)
 - f. Treatment plan and recommendations
 - g. Explanation to substantiate the necessity of retesting, if applicable

| TYPE OF BENEFIT | DESCRIPTION OF BENEFIT | LIMITATIONS AND/OR EXCLUSIONS | CO-PAY AND/OR DEDUCTIBLE |
|--|---|--------------------------------------|---|
| Outpatient Mental Health Services | <p>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> • Medication management visits do not count against the outpatient visit limit. • The visits can be furnished in a variety of community-based settings(including school and home-based) or in a state-operated facility • Up to 60 days 12-month period limit for rehabilitative day treatment • 60 outpatient visits 12-month period limit • 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost • 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on basis of financial equivalence against the outpatient visit cost • Includes outpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits | | <p>Schedule A: \$3 copayment for office visits. Schedule B: \$5 copayment for office visits. Schedule C: \$7 copayments for office visits. Schedule D: \$10 copayment for office visits.</p> |

| | | | |
|---|--|---|--|
| | <ul style="list-style-type: none"> • A qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services (DSHA) standards (TAC title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider, A QMHP must be working under the authority of an DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral | | |
| Inpatient Mental Health Services | <p>Mental Health services, including for serious mental illness, furnished in a free standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</p> <ul style="list-style-type: none"> • Neuropsychological and psychological testing. • Inpatient mental health services are limited to: • 45 days 12 month inpatient limit • Includes inpatient psychiatric services, up to 12 month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the determination | <p>Requires prior authorization for non-emergency services, Does not require PCP referral</p> | <p>Schedule A: \$10 inpatient copayment Schedule B: \$25 inpatient copayment Schedule C: \$50 inpatient copayment Schedule D: \$100 inpatient copayment</p> |

| | | | |
|--|--|---|---|
| | <ul style="list-style-type: none"> • 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services and sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cose • 20 of the inpatient days must be held in reserve for inpatient use only <p>Does not require PCP referral</p> | | |
| Outpatient Substance Abuse Treatment Services | <ul style="list-style-type: none"> • Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period) • Does not require PCP referral | May require prior authorization, Does not require PCP referral | <p>Schedule A: \$3 copayment for office visits.</p> <p>Schedule B: \$5 copayment for office visits.</p> <p>Schedule C: \$7 copayments for office visits.</p> <p>Schedule D: \$10 copayment for office visits.</p> |
| Inpatient Substance Abuse Treatment Service | <p>Services include, but are not limited to :</p> <ul style="list-style-type: none"> • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour | Require prior authorization for non emergency services, Does not require PCP referral | <p>Schedule A: \$10 inpatient copayment</p> <p>Schedule B: \$25 inpatient copayment</p> <p>Schedule C: \$50 inpatient copayment</p> |

| | | | |
|--|---|--|--|
| | <p>residential rehabilitation programs</p> <ul style="list-style-type: none"> • Does not require PCP referral • Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period. • 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost <p>30 days must be held in reserve for inpatient use only.</p> | | <p>Schedule D: \$100 inpatient copayment</p> |
|--|---|--|--|

B. PCP Requirements for Behavioral Health

1. Community First PCP’s may be allowed to provide Behavioral Health Services to members for services that fall within the scope of their credentialed specialty.
2. Utilizing assessment instruments for Behavioral Health Services that are available for the PCP.
3. Community First PCP’s must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

C. Behavioral Health Services

1. Behavioral Health Services are available to Community First CHIP members through the following:
 - a. Self-referral to any Community First participating Behavioral Health Provider.
 - b. Community First PCP’s may refer the member to a participating Behavioral Health Provider.
2. Coordination between physical health services and Behavioral Health services include the following:
 - a. Community First PCP’s may refer the member to a participating Behavioral Health Provider.

- b. Medical records documentation and referral information should be maintained using Diagnosis of Mental Health Syndrome (DMS-IV).
 - c. Maintenance of consents for disclosure of information. Behavioral health providers are required to send initial and quarterly summary reports to PCP.
 - d. Adherence to court-ordered commitments.
 - e. Coordination with the local mental health authority.
 - f. Assessment instruments
3. Requirements:
- a. Focus Studies and Utilization Management reporting: Focus studies are performed as part of the QMIP to objectively and systematically monitor and evaluate the quality of care and service provided to Community First CHIP Members. The studies are performed based on topics and tools agreed upon by the Quality Improvement Committee. Population samples are randomly selected and providers are notified of audits (if medical record review is necessary) at least 2 weeks in advance. Study findings are provided to providers through various methods including Community First's provider newsletter.
 - b. Procedures for follow-up of missed appointments.
 - c. Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
 - d. Community First requires that all Behavioral Health Providers contact Members, who have missed appointments within 24 hours to reschedule appointment.

V. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

A. Introduction

Our Quality Management and Improvement Program (QMIP) is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the health care delivery system. Components of this program include problem focused

studies, peer review, risk management, credentialing, compliance with external regulatory agencies, utilization management, medical records review, ongoing monitoring of key indicators, and health care services evaluation.

The purpose of our program is to assure the timely identification, assessment and resolution of known or suspected problems that may negatively impact the health and well-being of CHIP Members.

The QMIP is under the supervision of the Vice President of Health Services Management, the Medical Director and the Quality Improvement Committee.

B. General Requirements of the QMIP

The success of the QMIP depends upon your cooperation by:

1. Providing us with medical records concerning our CHIP Members upon request;
2. Maintaining the confidentiality of CHIP Member information;
3. Promptly responding to our phone calls or letters concerning Quality Management issues;
4. Cooperating with our Quality Improvement Committee proceedings; and
5. Participating on our Quality Improvement Committee, Credentials Committee, Utilization Management or Pharmacy and Therapeutics Committee, if appropriate. These committees consist of network providers who are board certified in their area of practice and are in good standing with Community First. If you are interested in joining any of these committees, please contact your Network Management Representative.

6. Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Network Provider contract and any records, books, documents, and papers that are related to the Network Provider contract and/or the Network Provider's performance of its responsibilities under this contract:
 - a. HHSC and MCO Program personnel from HHSC;
 - b. U.S. Department of Health and Human Services;
 - c. Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;
 - d. an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
 - e. state or federal law enforcement agency;
 - f. special or general investigation committee of the Texas Legislature;
 - g. the U.S. Comptroller General;
 - h. the Office of the State Auditor of Texas; and
 - i. any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

The Network Provider must provide access wherever it maintains such records, books, documents, and papers. The Network Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access may be for, but are not limited to, the following purposes:

- a. examination;
- b. audit;
- c. investigation;
- d. contract administration;
- e. the making of copies, excerpts, or transcripts; or

- f. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

C. Delegation of QMIP Activities

Community First delegated providers are required to have quality improvement programs in place for all delegated activities.

The delegated provider must submit quarterly reports to the Community First Quality Management Department regarding activities, including the results of reviews of potential quality issues and studies.

D. Credentialing and Recredentialing

All applicants for participation undergo a careful review of their qualifications, including education, training, licensure status, board certification, hospital privileges, and work and malpractice history. Providers who meet the criteria and standards of Community First are presented to the Credentials Committee for final approval of their credentials and participation with Community First.

Recredentialing is performed at least every three years. In addition to the verification of current license, DEA, malpractice insurance, National Practitioner Data Bank query and current hospital privileges, the process may also include:

1. CHIP Member survey results;
2. Complaints and Grievances;
3. Utilization data;
4. Compliance with Community First policies and procedures;
5. An office site review and evaluation, and;
6. A medical record audit.

VI. PROVIDER RESPONSIBILITIES

A. PCP (Medical Home) Responsibilities

1. PCP Availability and Accessibility Standards
Network PCPs must be accessible to CHIP Members 24 hours a day, 7 days a week, or make other arrangements for the provision of services. The following are examples of acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

a. *Acceptable:*

- i. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- ii. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient 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 phone. Another recording is not acceptable.
- iii. Office phone is transferred after hours to another location where someone will answer the phone, and be able to contact the PCP or another designated provider.

b. *Unacceptable:*

- i. The office phone is only answered during office hours.
- ii. The office phone is answered after hours by a recording, which tells patients to leave a message.
- iii. The office phone is answered after hours by a recording which directs patients to go to an emergency room for any services needed.

2. Verifying Member Eligibility and Benefits

Primary Care Physicians should always verify the eligibility of the CHIP Member prior to rendering services by calling Community First Member Service's Department at (210) 358-6300 during office hours.

B. Access and Availability Standards

The purpose of these guidelines is to ensure that health services are available and accessible to Community First members. Because Community First contracts with a closed panel of practitioners, it is essential that we have a sufficient number of practitioners in our network who are conveniently located to serve our enrollees. By monitoring compliance with these guidelines, Community First can identify opportunities to improve our performance, and to develop and implement intervention strategies to effect any necessary improvement.

Community First has Primary Care Physicians (PCP's) available throughout the service area to ensure that no member must travel more than 30 miles, or 45 minutes, whichever is less, to access the PCP.

Community First Providers shall be available to members by telephone twenty-four (24) hours a day, seven (7) days a week for consultation and /or management of medical concerns.

ACCESS STANDARDS

| TYPE OF APPOINTMENT | APPOINTMENT AVAILABILITY |
|---|---|
| Emergency Care, including Behavioral Health | 24 hours a day, 7 days a week, upon Member presentation at the deliver site, including non-network and out-of-area facilities. |
| Urgent Care (PCP) (Specialist) (Behavioral Health) | Within 24 hours of request Within 24 hours of request Within 24 hours of request |
| Routine Care (PCP) (Specialist) (Behavioral Health) Routine/schedule inpatient/outpatient care | 14 days or less of request 14 days or less of request 14 days or less of request |
| Behavioral health Discharge Planning/Aftercare | Members discharged from an inpatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments. |
| Initial Outpatient Behavioral Health visits | Within 14 days of request |
| Routine specialty care referrals | Within 30 days of request |
| Physical Examinations | 56 days or less (4-8 weeks) |
| Pre-Natal Care (Initial) | 14 calendar days or less or by the 12 th week of gestation. Members who |

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| | express concern about termination will be addressed as Urgent Care. |
| High-risk pregnancies or new members in the third trimester | Within 5 days or immediately if an emergency exist. |
| Well-Child Care (Including THSteps) Well adolescent care | STAR Well-Child/THSteps: For newly enrolled members under age 21, overdue or upcoming well-child checkups as soon as practicable and no later than 60 days of enrollment for other eligible child members. Routine Well-child Care: In accordance with American Academy of Pediatrics periodicity schedule. |
| Texas Health Steps checkups | Within 14 days of enrollment and no later than 60 days of enrollment for other eligible child members and in accordance with American Academy of Pediatrics periodicity schedule. |
| Migrant Farm Worker Children | Staff must ensure prompt delivery of services to children of migrant farm workers and other migrant population who may transition into or out of HMO program more rapidly and/or unpredictable than the general population. |
| Newborn Care (in a hospital) | Newborns must receive an initial newborn checkup before discharge from the hospital. |
| Newborn Care (after discharge from a hospital) | Within 14 days of hospital discharge. |
| Preventative health services for children and adolescents | Within 60 days of request in accordance with American Academy of Pediatrics periodicity schedule |
| Preventive health services for adults | Within 90 days of request in accordance with US Preventive Services Task Force recommendations |
| Physical Therapy | Within 24 hours (urgent) 3 days or less (routine) 14 days or less (follow-up) |
| Radiology | Within 24 hours (urgent) |

| | |
|---|--|
| | 7 days or less (MRI/CT Scan) 10 days or less (IVP/UGI) 21 days or less (Mammogram) |
| Home Health/DME/Supplies (OT, PT, ST SNV, etc) | Within 2 hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection. |
| Provider office waiting time | Within 30 minutes of scheduled appointment time. |
| Request for feedback from pharmacy related to prescriptions | Within 24 business hours |

C. Plan Termination

1. Provider Request for Termination

The Provider may terminate the Agreement with Community First, as of any date, by giving written notice of such intent at least sixty (60) days in advance. In the event of termination, the obligations of Provider and Community First under the Agreement shall continue in full force and effect with respect to existing Members for a period not to exceed sixty (60) days from the date of notice of contract termination. The parties may, however, agree to an earlier terminate date at the discretion of Community First.

2. Health Plan Request for Termination

Community First must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a provider, including a Significant Traditional Provider (STP). At least 30 days before the effective date of the proposed termination of the provider’s contract, Community First must provide a written explanation to the provider of the reasons for termination. Community First may immediately terminate a provider contract if the provider presents imminent harm to patient health, actions against a license or practice, fraud or malfeasance. Within 60 days of the termination notice date, a provider may request a review of Community First proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license, fraud or malfeasance. The advisory review

panel must be composed of physicians and providers, as those terms are defined in §843.306

D. Members Right to Designate an OB/GYN

Community First *does not* limit the CHIP member's selection of an OB/Gyn to the PCP's network. However, CHIP Member's must select an OB/Gyn that participates with Community First's CHIP provider network.

You have the right to select an OB/GYN without a referral from your PCP. The access to health care services of an OB/GYN includes:

1. One well-woman check-up per year
2. Care related to pregnancy
3. Care for any female medical condition
4. Referral to special doctor within the network

E. Referral to Specialists and Health Related Services

1. The **Texas Referral Authorization Form (Exhibit 21)** serves as a documentation tool for communication of:
 - a. PCP to a Specialty Care Provider
 - b. Specialty Care Provider to another Specialty Care Provider within the scope of the original diagnosis and treatment plan of care.
2. PCP may provide Behavioral Health related services within the scope of it's practice.
3. Community First will authorize referrals to participating Facilities and Contractors.
4. Community First will work with participating providers for CHIP member's who request a second opinion.

F. Specialty Provider Responsibilities

The specialty care provider is responsible for providing medically necessary services to Community First CHIP Members who have been referred by their PCP for specified treatment or diagnoses. Specialists should always verify the eligibility of the referred CHIP Member prior to rendering services. Specialists requesting services that require authorization must request the

authorization from Community First's Health Services Management Department, prior to rendering services. The Specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the continuity and quality of care. Referrals from the PCP must be documented in both the PCP's and Specialist's medical records.

1. Acceptable:

- a. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- b. Office phone is answered after normal business hours by a recording in the language of each of the major population groups served directing the patient 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 phone. Another recording is not acceptable.
- c. Office phone is transferred after hours to another location where someone will answer the phone, and be able to contact the PCP or another designated provider.

2. Unacceptable:

- a. The office phone is only answered during office hours.
- b. The office phone is answered after hours by a recording, which tells patients to leave a message.
- c. The office phone is answered after hours by a recording which directs patients to go to an emergency room for any services needed.

G. Verifying Member Eligibility and Benefits

Specialists should always verify the eligibility of the referred CHIP Member prior to rendering services

H. Costs of Non-Covered Benefits

Providers must inform Members of costs for non-covered services prior to rendering such services and must obtain a signed **Private Pay Agreement (Exhibit 19)** from such a Member.

I. Member's Continuity of Care

Community First provides CHIP Members with a process to address continuity of care issues involving continuation/transition of ongoing care and to request the use of a specialist as their Primary Care Physician (PCP). This policy outlines the situations and describes the process for requesting this type of coverage.

Continuity of Care coverage can be approved for two different circumstances as outlined below:

1. Transition of Care (i.e. members moving outside of service area)
2. Specialty Care Provider (SCP) as PCP

J. Transition of Care

Community First recognizes that Members/potential Members may have concerns about changing health plans or the need to change providers due to a provider terminating his/her contract with CFHP, as either of these may affect the ongoing care they receive. Transition of Care involves any ongoing active course of treatment, the current phase for which the interruption of service might possibly cause undue harm to the member. The treatment must be acute in nature. Some common examples of the conditions to which this policy refers are:

1. Behavioral Health Care (Mental Health or Chemical Dependency)
Member is currently in a course of active treatment and any alteration would likely be detrimental to the Member.
2. Cancer Treatment
Member is currently in a course of chemotherapy or radiation therapy given by a specialty Provider.
3. Pregnancy
The Member is in the third trimester or the second trimester, if high-risk
4. Terminal Illness
The Member's life expectancy is less than 6 months.

See **Exhibit 1**, Transition of Care Request Form

K. Medical Records Standards:

Standards that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (IPAA) and other federal and state laws.

CFHP follows 1997 CMS and current *American Medical Association (AMA) Current Procedural Terminology (CPT)* documentation and coding guidelines as stated in the Texas Medicaid Provider Procedures Manual.

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandate the use of national coding and trans- action standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

Past Medical History – why is this for visits of three or more? This is a “component of the history element for every visit– without it a lower CPT code would be warranted. I would just include a “relevant past medical history for each encounter.”

L. Amendment of Medical Records

CFHP follows the Texas Administrative Code, Title 22, Part 9 Charter 165 Rule 165.1 guidelines for the amendment of medical records.

- The provider must have specific recollection of the services provided which is documented.
- A provider may add a missing signature without a time restriction if the provider created the original documentation him/herself.
- The above does not restrict or limit the provider's ability to document or amend medical records at any time to more accurately describe the clinical care provided to the patient.

- For medical record review/audit and reimbursement purposes. Documentation is not considered appropriate and/or timely documented if originally completed after thirty (30) days of the date of service.

DEFINITIONS:

Late entry: supplies additional information that was omitted from the original entry. The late entry is added as soon as possible, reflects the current date and is documented and signed by the performing provider who must have total recollection of the service provided.

Addendum: provides additional information that was not available at the time of the original entry. The addendum should be timely, reflect the current date, provider signature and the rationale for the addition or clarification of being added to the medical record.

Correction: revisions of errors from the original entry which make clear the specific change made, the date of the change and the identity of the person making the revision. Errors must have a single line through the incorrect information that allows the original entry to remain legible. The correct information should be documented in the next line or space with the current date and time, making reference back to the original entry.

M. Access to Medical Records

Provider agrees to provide the Texas Health and Human Services Commission (HHSC):

1. all information required under the Community First's managed care contract with HHSC, including but not limited to the reporting requirements and other information related to the provider's performance of its obligations under the contract; and
2. any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

N. Coordination with Texas Department of Family and Protective Services (DFPS)

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

1. Providing medical records; and
2. Recognition of abuse and neglect, and appropriate referral to DFPS

O. Reporting of Suspected Sexual Abuse or Neglect of a Child

Provider is to comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to reporting suspected child abuse and neglect and the provisions of the Texas Department of State Health Services (DSHS) policy.

P. Justification to Community First regarding Out of Network Referrals Including Partners Not Contracted with Community First.

When Community First recognizes that a specialty care provider is unavailable in the network, on a case by case basis, a Letter of Agreement (LOA), is generated to allow an out of network provider to render services to a CHIP member.

VII. ROUTINE, URGENT AND EMERGENCY SERVICES

A. Emergency Care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the CHIP Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in:

1. Placing the CHIP Member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction to any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Community First covers services for a medical emergency anywhere in the world, 24 hours a day. If a medical emergency occurs, whether in or out of Community First's service area, CHIP Members are instructed to seek care at the nearest hospital emergency room or comparable facility. The necessary emergency care services will be provided to covered CHIP Members, including transportation, treatment and stabilization of an emergency medical condition, and any medical screening examination or other evaluation required by state or federal law which is necessary to determine if a medical emergency exists.

When the condition of the CHIP Member requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance is an emergency service. If a CHIP Member needs to be transferred to another facility and the medical condition of the CHIP Member requires immediate medical attention, the transfer may be considered as an emergency transfer.

Community First must be notified of emergency admissions, transportations or procedures within 24 hours, or the next business day.

If it is determined that a medical emergency does not exist (emergency care is not rendered), the CHIP Member must contact his or her PCP to arrange any non-emergency care needed. If the CHIP Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the CHIP Member may be transferred to a network hospital as soon as the attending provider deems it medically appropriate. Once the patient/member is stabilized, the treating provider is required to contact Community First to obtain authorization for any necessary post-stabilization services.

B. Urgent Care

An *urgent condition* means a health condition, including an urgent behavioral health situation, which 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 CHIP Member’s PCP or PCP designee to prevent serious deterioration of the CHIP Member’s condition or health.

For after hours urgent care, and certain instances during normal office hours, Community First has arrangements with Urgent Care Clinics listed in the Provider Directory. In addition, we have arrangements with the **Nurse Advice Line, (210) 358-6300 or 1-800-434-2347** a **24-hour** nurse advice service staffed by registered nurses who provide advice according to written protocols, and assist CHIP Members in accessing treatment.

Services provided at the Urgent Care Clinics are limited to:

1. After Hours Urgent Care

| | | |
|----------|---------------------------------|--|
| Weekdays | Monday-Friday | 5:00 p.m. – 8:30 a.m. |
| Weekends | Friday-Monday | Friday 5:00 p.m. – Monday 8:30 a.m. |
| Holidays | Preceding Day- Following Day | Day Prior 5:00 p.m. – Day After 8:30 a.m. |

2. During Normal Office Hours

You may refer a patient to an Urgent Care Clinic during normal office hours only if the PCP is unavailable, and a triage nurse has determined that the patient requires urgent care, *not hospital emergency care*. The PCP's nursing staff should triage the patient or refer to the Nurse Advice Line if the PCP's nursing staff is unavailable.

Referrals to the Urgent Care Clinic: When referring a CHIP Member to an Urgent Care Clinic, the PCP or PCP's nursing staff should call the clinic and notify the clinic they are referring the patient. If a CHIP Member goes to one of the clinics without approval, the clinic must contact the PCP. If the PCP does not respond within a reasonable length of time, depending on the medical situation, the clinic should call Community First Health Services Management Department, or the Nurse Advice Line.

If the examining physician determines that a *true medical emergency exists*, the CHIP Member will be admitted to the nearest hospital emergency department appropriate for the patient's condition. If a *medical emergency does not exist*, but the examining physician determines that hospitalization is necessary for further evaluation and/or treatment, the PCP will be contacted to affirm concurrence in admitting the patient. It will then be the PCP's responsibility to arrange admission to a Community First network hospital.

C. Emergency and Non-Emergency Transportation

1. When an emergency situation exists, a prudent lay person determines that there could be a loss of life or limb definition of emergency health condition. This requires use of special equipment, life support systems, and close monitoring by trained attendants while in route to the nearest appropriate facility, the ambulance transport is an emergency service.
2. When a non-emergency situation exists, requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transport, the ambulance transport is a non-emergency service.

D. Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or PA edit and would need prescriber prior approval.

E. State Fair Hearing Information

Can I ask for a State Fair Hearing?

If the Member disagrees with the health plan's decision, the Member has the right to ask for a fair hearing. The Member may appoint, in writing, a representative. A provider may be a Member's representative. The Member or Member representative must ask for the fair hearing within 90 days of the date on the health plan's letter. If the Member does not ask for the fair hearing within 90 days, the Member may lose his/her right to a fair hearing. To request a fair hearing, the member or Member representative contacts the health plan either in writing at (4801 NW Loop 410 Suite, 1000, San Antonio, Texas 78229) or by telephone at (210)358-6000.

The Member has the right to continue any service he/her is now receiving until the final hearing decision if the member requests the fair hearing within ten days from receipt of the hearing notice from the health plan. If a fair hearing is not requested within ten days from receipt of the hearing notice, the services being appealed will be discontinued.

The Member does not have a right to a fair hearing if Medicaid does not cover the service requested.

If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time and location of the hearing. Most fair hearings are held by telephone and the Member or the Member's representative may tell why he/she asked for the service.

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

VIII. CHIP PROVIDER COMPLAINTS AND APPEALS

A. Provider Complaint and Appeal Process

Community First has a process to address provider complaints in a timely manner, which is consistent for all network providers. Community First and the provider have an obligation under their mutual contract provisions to make a good faith effort to resolve any disputes arising under the agreement. In the event a dispute cannot be resolved through informal discussions, the provider must submit a complaint to Community First, which specifically sets forth the basis of the complaint along with a proposed resolution. Providers should submit complaints, verbally or in writing, to Community First's Network Management Department.

1. Provider Complaints

Upon receipt of a written provider complaint, the Network Management Department will send a letter acknowledging receipt of the complaint within five (5) working days from the date of receipt. If the provider complaint is received orally, the Network Management Department will

send a **Provider Complaint Form (Exhibit 3)** with a transmittal letter. The provider must complete the form and return the form to Community First's Network Management Department for prompt resolution of the complaint. Once the Provider Complaint Form is received by Community First's Network Management Department, a letter will be sent acknowledging receipt of the complaint within five (5) working days from the date of the receipt.

2. Provider Appeals

Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First's resolution of the complaint to the provider within 30 calendar days from the receipt of the written complaint or completed Provider Complaint Form.

If the provider and Community First are unable to resolve the complaint, the provider may submit an appeal, orally or in writing, to Community First. Upon receipt of a written appeal, Community First will send a letter acknowledging the request for an appeal within three (3) working days from the date of receipt. If the appeal is received orally, Community First's Network Management Department will send an **Provider Appeal Form (Exhibit 4)** to the provider to complete and return to Community First.

Community First will send written notification within 30 calendar days from the receipt of the appeal to the provider of the acceptance, rejection or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First's final determination. The notification will advise the provider of his or her right to submit the appeal to binding arbitration. Any binding arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association, unless the provider and Community First mutually agree to some other binding arbitration procedure.

Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and member complaints.

Please be informed that you have the right, at any time, to contact the Texas Department of Insurance at 1-800-252-3439.

IX. CHIP MEMBER COMPLAINTS AND APPEALS

A. Member Complaint Process

1. If a CHIP Member or family has a problem or concern regarding the delivery of their health care, a written complaint may be submitted to the Community First Member Services:

Resolution Unit
Community First Health Plans
4801 NW Loop 410, Ste. 1000
San Antonio TX 78229

**Effective April 3, 2009 submit to new address below:
Community First Health Plans Inc.
ATTN: Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, Texas 78247**

What should I do if I have a Complaint?

If a CHIP Member or family has a problem or concern regarding the delivery of their health care, a written complaint may be submitted to the Community First Member Services:

Who do I call and can someone help me file a Complaint?

Call the Member Services Department Monday thru Friday 8:30 A.M. until 5:00 P.M. at 210-358-6300/1-800-434-2347 or TDD 210-358-6080. A Member Services representative will help the CHIP Member with any issues and concerns the CHIP Member may have. After hour services are provided for both Members and Providers at the same number.

How long will it take to process a complaint?

Community First has thirty (30) days to complete a complaint from the date of receipt of the response letter from the member. If I am not satisfied with the outcome, who else can I contact?

Texas Department of Insurance (TDI)
P. O. Box 149104
Austin, Texas 78714-9104
or call toll free at 1-800-252-3439

B. Member Appeal Process

Community First CHIP Member's may request an appeal if the CHIP Member is not satisfied with the outcome of the complaint process or if Community First denies or limits a request for a covered service.

What can a Community First CHIP Member do if Community First denies or limits a request for a covered service?

The Member may request a formal hearing with Community First's resolution unit.

How will the Community First CHIP member be notified if services are denied?

The Member will receive a formal letter from Community First explaining the decision.

What is the time frame for the appeal process?

Community First has thirty calendar days from the receipt of the appeal to process the appeal.

When does a member have the right to request an appeal?

The Member has the right to an appeal if they are not satisfied with the decision from Community First.

Oral appeals that are received by Community First must be confirmed by a written appeal, signed by the member or his/her representative, unless an expedited appeal is requested.

Can a representative from Community First help the CHIP members file an appeal?

Members may request assistance from a Community First Member Services Representative when filing an appeal.

C. Expedited Community First Member Appeal

Community First CHIP Member's may request an expedited appeal if the CHIP Member is not satisfied with the outcome of the complaint process.

How can a Community First CHIP member request and expedited appeal?

Community First CHIP member may request and expedited appeal orally or in writing, when Community First is required to make a decision quickly based on the member's health status and taking the time for a standard appeal could jeopardize the members health.

What is the timeframe for an expedited appeal?

The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed (1) working day following the date that the appeal, including all necessary information to complete the appeal, is made to Community First.

Who can assist in filing an appeal?

Community First Member Services can assist when a CHIP member files an appeal.

What happens if Community First denies the request for an Expedited Appeal?

We will notify you. Your request will be moved to the regular appeal process and we will mail you our decision within 30 days.

D. Member Independent Review Organization (IRO) Process

What is an IRO?

An IRO is an Independent Review Organization that is not part of Community First. The IRO reviews unresolved appeals, as coordinated by the Texas Department of Insurance.

How does a Community First CHIP member request an IRO?

The Community First CHIP Member should contact the Texas Department of Insurance:

Texas Department of Insurance (TDI)
P. O. Box 149104
Austin, Texas 78714-9104
or call toll free at 1-800-252-3439

What are the timeframes for requesting, reviewing and resolution of an IRO?

IRO timeframes are determined by the Texas Department of Insurance.

X. CHIP MEMBER ELIGIBILITY AND ADDED BENEFITS

A. Member Eligibility

Each CHIP Member is issued an Identification Card and is instructed to present the Community First CHIP ID Card when requesting medical services. The CHIP ID Card indicates pertinent CHIP Member information, PCP name and telephone number, Co-payment amounts and Community First telephone numbers.

At the time of the visit, ask the CHIP Member to show the Community First CHIP ID, card, or in some instances, the CHIP Enrollment form (for the first thirty days after enrollment). The Community First CHIP ID Card, however, does not guarantee eligibility for coverage.

If a CHIP Member has selected a PCP who is part of a Limited Provider Network you may not see that CHIP Member unless you have written authorization from the Limited Provider Network. Any services except emergencies will not be reimbursable.

Confirming eligibility before rendering services is essential. Listed below are helpful ways to confirm eligibility:

1. Call Member Services at **210-358-6300** (outside Bexar County **800-434-2347**)
2. On-line, Above Health
3. On-line, Web-Site is www.cfhp.com

When a CHIP Member has questions about benefit coverage or wants to change to another PCP, please ask the CHIP Member to call our Member Services Department at **210-358-6300** or **800-434-2347**.

B. Pregnancy and CHIP Eligibility

CHIP Members should contact Community First Member Services as soon as the member is aware of the pregnancy. The pregnant member needs to immediately apply for Medicaid benefits. Providers are required to contact Community First when a pregnant CHIP member is identified.

The newborn will be enrolled in Medicaid from birth to a year if the member enrolls in Medicaid while she is pregnant. If the member does not enroll in Medicaid while she is pregnant, she will have to apply for coverage for her newborn after the newborn is born, otherwise, there could be a gap in coverage for her newborn. Community First will not be financially responsible for the newborn.

C. Span of Eligibility

Community First will arrange for all covered services for the period CHIP Members are eligible with Community First's CHIP Program. Eligibility is spanned in 12 month increments. Determination of eligibility is assumed by the Administrative Services Contractor.

Covered CHIP services must meet the CHIP definition of "medically necessary." "Medically Necessary" health services are:

1. Physical:

- a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;
- b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of Members' medical conditions;

- c. Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- d. Consistent with the diagnoses of the conditions; and
- e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

2. Emergency Care:

Emergency care is a covered CHIP service. “Emergency” and “emergency condition” means a medical condition of recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the child’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- a. Placing the child’s health in serious jeopardy;
- b. Serious impairment to bodily functions;
- c. Serious dysfunction of any bodily organ or part;
- d. Serious disfigurement; or
- e. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

“Emergency services” and “emergency care” means health care services provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency condition exists.

There is no lifetime maximum on benefits; however, bi-annual (**a 12-month period**) or lifetime limitations do apply to certain services, as specified in the following chart. Deductibles and copays apply until a family reaches its specific cost-sharing maximum.

D. Identifying CHIP Members

SAMPLE CHIP Member Identification Card (Exhibit 5)



XI. MEMBER RIGHTS AND RESPONSIBILITIES

A. Member Rights and Responsibilities

Listed below are the Rights and Responsibilities for Community First CHIP Members:

1. Member Rights:

- a. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
- b. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. You can't see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care physician and any specialist doctor you might like to see are part of the same "limited network."
- c. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know what those payments are and how they work.
- d. You have a right to know how the health plan decides about whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decides those things.
- e. Your health plan may make you only use drugs from an approved list.

This is called a "drug formulary" and you have the right to know which drugs are on it.

- f. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
- g. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
- h. If your child is confirmed to have special health care needs or a disability, you may be able to use a specialist as your child's primary care physician. Ask your health plan about this.
- i. Children who are confirmed to have special health care needs or a disability have the right to special care.
- j. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Contact Community First Health Services Management at 210-358-6050 for information.
- k. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care physician and without first checking with Community First. Contact Community First Member Services at 210-358-6300 for information.
- l. You have a right to emergency services when you need them if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with Community First. You may have to pay a co-payment in the CHIP Program, depending on your income
- m. You have the right and responsibility to take part in all the choices about your child's health care.
- n. You have the right speak for your child in all treatment choices.
- o. You may have a right to get a second opinion from another doctor in Community First's Network, with a referral from your PCP.
- p. You have the right to be treated with respect and kindness when you visit a doctor's office, go to the hospital, or talk to your health plan.
- q. You have the right to talk to your child's doctors and other providers

in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

- r. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it won't pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

2. Member Responsibilities

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

- a. Try to follow healthy habits. Encourage your child to exercise, to stay away from tobacco, and to eat a healthy diet.
- b. Become involved in the doctor's decisions about your child's treatments.
- c. Work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
- d. If you have a disagreement with your health plan, try to first resolve it using the health plan's complaint process.
- e. Learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
- f. If you make an appointment for your child, try to get to the doctor's office on time. If you can't keep the appointment, be sure to call and cancel it.
- g. Remember to pay your doctor and other providers what you owe them. Keep track of what you pay.
- h. Report misuse of the CHIP program by health care providers, other CHIP members, or CHIP health plans.
- i. If you choose to take your child to another doctor who is not your child's PCP for any services normally provided by your PCP, you may be asked to sign a form making you responsible for the bill. Your PCP is in charge of managing your health care.

- j. This does not apply to your first visits for obstetrics/gynecology services. If you need care from a specialist, your PCP will arrange it for you by giving you a referral to see that special doctor.

XII. LEGAL AND REGULATORY GUIDELINES

The Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Provider Contract and Community First managed care contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Provider contract, or any violation of Community First's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law

A. Law, Rules and Regulations

The Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Provider contract:

1. environmental protection laws:
 - Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
 - National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
 - Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
 - State Clean Air Implementation Plan (42 U.S.C. §740 *et seq.*) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
 - Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;
2. state and federal anti-discrimination laws:

- Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
 - Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
 - Americans with Disabilities Act of 1990 (Public Law 101-336); and
 - Title 40, Texas Administrative Code, Chapter 73;
3. the Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.*) regarding employment verification and retention of verification forms; and
 4. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).

B. Liability

1. In the event Community First becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against Community First will be through Community First's bankruptcy, conservatorship, or receivership estate
2. The Provider understands and agrees that Community First's Members may not be held liable for Community First's debts in the event of the entity's insolvency.
3. The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, Community First, its employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by Community First or any judgment rendered against Community First. HHSC's liability to the Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 *et seq.*).

C. Member Communications

Community First is prohibited from imposing restrictions upon the Provider's free communication with a Member about the Member's medical conditions, treatment options, Community First's referral policies, and other Community First

policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts

D. Provider Requirements, CHIP Agreements, TPI and NPI

Acute Care Providers serving CHIP Members must enter into and maintain a CHIP provider agreement with HHSC or its agent to participate in the CHIP Program, and must have a Texas Provider Identification Number (TPIN). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2008.)

E. Professional Conduct

While performing the services described in the Network Provider contract, the Network Provider agrees to:

1. comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
2. otherwise conduct themselves in a businesslike and professional manner.

F. Terminations for Gifts or Gratuities

Provider may not offer or give any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than \$50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. The MCO may terminate this Network Provider contract at any time for violation of this requirement.

G. Professional Liability Insurance

Provider shall maintain, during the term of the Network Provider contract, Professional Liability Insurance of \$200,000 per occurrence and \$600,000 in the aggregate, or the limits required by the hospital at which Network Provider has admitting privileges.

[NOTE: The provision will not apply if the Network Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act.]

H. On-Site Reviews

As part of our QMIP, we will be conducting periodic facility and medical record audits for PCPs and high volume specialists. The reviews are used in the recredentialing process. Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled in a confidential manner and organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries and other pertinent medical information are readily accessible, and that the events are documented clearly and completely. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Record reviews are considered an essential method of identifying potential quality of care issues and opportunities for Practice Guideline development.

Community First has adopted medical record standards that assist with evaluating patient care to ensure conformance with quality of care standards. Providers must conform to the standards to remain a network provider. Providers will be evaluated at least every two years. The Quality Management Department, prior to the review, will notify you of the scheduled audit. The audit routinely consists of four components:

1. Documentation
2. Continuity of Care
3. Preventive Care
4. Facility Site Review

A copy of the **Provider Office Assessment Tool (Exhibit 7)**, the **Physician Medical Record Audit Tool (Exhibit 8)**, and the **Pediatric Preventive Care Recommendations (Exhibit 9)** are enclosed in this manual for your review. You will receive written feedback on the results of the record review along with any recommendations regarding documentation. A Corrective Action Plan will be required for those areas with scores below the established benchmarks. The Community First Quality Management Department may provide educational assistance with medical record documentation, if requested. Repeat audits will be performed if problems are identified. Results of medical record audits are trended and reported to the Quality Improvement Committee to identify areas needing improvement or revisions to the Community First medical record standards.

I. Practice Guideline Development

In an effort to provide and maintain quality health care and preventive service, Community First has established a process for evaluating patterns of care for specific

conditions and procedures. The Quality Improvement Committee has developed adult and pediatric Preventive Care Guidelines. Compliance with the guidelines is evaluated during the medical record reviews. In addition, the Quality Improvement Committee has approved the following practice guidelines:

The success of the QMIP depends upon your cooperation by:

- Providing us with medical records concerning our CHIP Members upon request;
- Maintaining the confidentiality of Member information;
- Promptly responding to our phone calls or letters concerning Quality management issues;
- Cooperating with our Quality Improvement Committee proceedings;
- Participating on our Quality Improvement Committee, Credentials committee, Utilization Management or Pharmacy and Therapeutics Committee, if appropriate. These committees consist of network providers who are board certified in their area of practice and are in good standing with Community First Health Plans. If you are interested in joining any of these committees, please contact your Network Management Representative.

J. Pre-existing Conditions

Community First is responsible for arranging for the provision of all covered services to each eligible Community First CHIP Member beginning on the CHIP Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. All arrangements for covered services will be in accordance with contractual requirements between Community First and provider.

K. Confidentiality

Provider must treat all information that is obtained through the performance of the services included in this Provider Manual or the Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to information relating to applicants or recipients of HHSC Programs.

Provider shall not use information obtained through the performance of the Provider contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Provider contract.

Provider shall protect the confidentiality of Member Protected Health Information

(PHI), including patient records. Providers must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

L. Fraud Reporting

1. Reporting Provider or Recipient Waste, Abuse or Fraud for CHIP

- a. If you suspect a client (a person who receives benefits) or a provider (e.g., doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.
- b. Reporting Provider/Clients Waste, Abuse and Fraud

You can report providers / clients directly to your health plan at:

**Community First Health Plans
4801 NW Loop 410, Suite 1000
San Antonio, Texas 78229
1-800-434-2347**

**New Address Effective April 3, 2009
Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249**

Or if you have access to the Internet go to HHSC OIG website at <http://www.lhs.state.tx.us> and select "Reporting Waste, Abuse and Fraud". The site provides information on the types of waste, abuse and fraud to report. If you do not have Internet access and prefer to talk to a person, call the Office of Inspector General (OIG) Fraud Hotline at 1-800-436-6184,

You may send a written statement to the following OIG addresses:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

To report clients, use this address:

Office of Inspector General
General Investigations/Mail Code 1362

P.O. Box 85200
Austin, TX 78708-5200

2. Provider understands and agrees to the following:

- a. HHSC, Office of Inspector General (“OIG”) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Providers and their employees; agents, contractors, and patients;
- b. requests for information from such entities must be compiled with, in the form and language requested;
- c. Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pretrial conference, hearings, trials and in any other process, including investigations at the Provider’s own expense; and
- d. compliance with these requirements will be at the [Provider’s] own expense.

3. Provider understands and agrees to the following:

- a. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;
- b. Providers must cooperate and assist HHSC and any state or federal agency that is charged with duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
- c. Providers must provide originals and/or copies of any and all information allow access to premises, and provide records to the Office of the General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General’s Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge.
- d. If the Provider places required records in another legal entity’s records, such as a hospital, the Network Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and

e. Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by Community First or a Member to the HHSC Office of Inspector General

4. **“Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care,”** published by the federal government in October 2000, is an excellent guide as to what constitutes fraud and abuse in a managed care setting. You may access this guide at the following link: <http://cms.hhs.gov/states/fraud/fraudgd.pdf>

If you suspect someone of fraud and abuse, please report them to the following:

Community First Health Plans
Director of Member Services
4801 NW Loop 410, Ste 1000
San Antonio, TX 78229

Effective April 3, 2009 address change

12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

Written complaints should be mailed to:

HHSC Office of Inspector General (OIG)

To report providers:
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, Tx. 78708-5200

To report clients:
Office of the Inspector General
General Investigations/Mail Code 1362
P.O. Box 85200
Austin, Tx 78708-5200

Fraud Hotline 1-800-436-6184

<http://www.hhsc.tx.us>

5. **Reporting Provider/Recipient Fraud, Waste and Abuse:**

Community First has established several mechanisms that can be utilized for the reporting of suspected acts of waste, abuse and fraud. The Suspicious

Activity Report (SAR) form is available and may be requested by your provider relations representative. Two internal numbers are available which can be used to report any suspicious activity.

Before April 3, 2009 report to address below:

Community First Health Plans Inc.
ATTN: Special Investigations Unit
4801 NW Loop 410
Suite 1000
San Antonio, TX 78229

Effective April 3, 2009 report to new address below:

Community First Health Plans Inc.
ATTN: Special Investigations Unit
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

Fraud Waste and Abuse Hotline message center: (210)358-6332

Community First Health Plans Inc. toll free # 1-800-434-2347

M. Special Investigation Unit

In response to rules enacted on May 13, 2004, by the State of Texas under Title 1, Chapter 353, a Special Investigation Unit (SIU) has been established by Community First Health Plans (CFHP).

CFHP is committed to protect and preserve the integrity and availability of health care resources to our recipients, our healthcare partners and the general community. CFHP performs these activities through its Special Investigation Unit to detect, prevent and eliminate waste; abuse and fraud at the provider, recipient and health plan level. CFHP utilizes electronic systems and training of our employees, contractors and agents to identify and report possible acts of waste, abuse and fraud. When such acts are identified, CFHP seeks effective remedies to identify overpaid amounts; recover identified amounts, prevent future occurrences of waste, abuse and fraud; and report offenses to the appropriate agencies when necessary.

1. Waste

Acts of **waste** are defined as activities involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent but that the outcome of poor or inefficient methods results in unnecessary costs to the Medicaid/CHIP program.

2. Abuse

Acts of **abuse** are defined as activities that unjustly enrich a person through the receipt of benefit payments but where the intent to deceive is not present, or an attempt by an individual to unjustly obtain a benefit payment.

3. Fraud

Fraud is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.

CFHP considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjustly benefit payments is not considered unless there is documented previous education in writing or in person by CFHP regarding the same or similar adverse audit findings or there is obvious program violations.

N. Fraud and Abuse Compliance Program

Community First is subject to all state and federal laws and regulations relating to fraud and abuse in health care. Community First has a fraud and abuse program known as the Special Investigation Unit in place designed to:

1. Prevent and detect potential or suspected fraud and abuse in the administration and delivery of services; and
2. Allow Community First to cooperate and assist any state or federal agencies charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse.

O. Audit or Investigation

Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider contract and any records, books, documents, and papers that are related to the provider contract and/or the provider's performance of its responsibilities under this contract:

1. HHSC and Community First Program personnel from HHSC;
2. U.S. Department of Health and Human Services;
3. Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;

4. an independent verification and validation contractor or quality assurance contract acting on behalf of HHSC;
5. state or federal law enforcement agency;
6. special or general investigation committee of the Texas Legislature;
7. the U.S. Comptroller General and the Office of the State Auditor of Texas; and
8. any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

The Provider must provide access wherever it maintains such records, books, documents, and papers. The provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access maybe for, but are not limited to, the following purposes:

1. examination;
2. audit;
3. investigation;
4. contract administration
5. the making of copies, excerpts, or transcripts; or
6. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

[Provider] understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. [Provider] further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.

XIII. CHIP ENCOUNTER DATA BILLING AND CLAIM ADMINISTRATION

A. Where to Send Claim/Encounter Data?

The **address** for submitting HMO, Medicaid and CHIP claims is:

Community First Health Plans, Inc.
4801 NW Loop 410, Suite 1000
San Antonio, TX 78229

Effective April 3, 2009 report to new address below:

Community First Health Plans Inc.
ATTN: Claims Department
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

Direct any questions regarding claims to Community First's Claims Customer Service Department at **210-358-6200**.

Community First receives a significant number of paper claims on a monthly basis. Our goal is to process your claims as quickly as possible. To expedite claim processing we are asking your assistance with the following:

1. Submit paper claims through normal mail delivery **unless** you are in jeopardy of missing the filing deadline and you require proof of timely filing.
2. Use 10"X13" envelopes; send multiple claims in one envelope.
3. Do not staple, paper clip or fold claim forms or attachments.
4. Do not use red ink.
5. Claims must be legible and readable. Handwritten claims are difficult to scan.

Tips: Change your printer ribbon frequently so information on the claim is visible and can be scanned. When printing your claim forms make sure the printer is online and the information prints within the correct field.

B. Claim Form to Use

Community First CHIP claims are processed within 45 days of receipt of the claim. CHIP claims must be filed on either a **CMS-1500 or UB-04** claim forms and must meet the requirements of a clean claims as defined under Article 20A, 18B, Texas Insurance Code and 28 TAC § 21.2801, et. Seq., as such statute or regulations may be amended from time to time to be eligible for penalty payment. **In order to submit a clean claim, Provider must provide the following information with the claim:**

1. Physician Services, DME and Supplies and Ambulance

Claims must be filed on a **CMS 1500 (Exhibit 10)** with the following information:

- a. Member's CHIP D number (Box 1a);
- b. Member's name (Box 2);
- c. Member's date of birth and sex (Box 3);
- d. Member's address (Box 5);
- e. Information on any other coverage applicable to the Member (Box 9,9a,9b,9c,9d & 10a,10b,10c);
- f. Referring physician's name, if applicable (Box 17);
- g. Referring physician's TPI and NPI (Box 17a and 17b)
- h. ICD-9 diagnosis code(s) (Box 21);
- i. Authorization number (Box 23), if applicable;
- j. Date(s) of service (Box 24A);
- k. Place of service (Box 24B);
- l. CPT-4 procedure code(s) with modifiers where appropriate (Box 24D);
- m. Charge of service (Box 24F)
- n. Rendering provider TPI and NPI (Box 24J)
- o. Tax ID Number of the physician performing the service (Box 25);
- p. Total charge (field 28);
- q. Signature of the physician performing the service (Box 31) (a legible signature stamp is preferred);
- r. Name and address of facility where services rendered (other than home or office (field 32);
- s. Name and address of the billing provider (field 33);
- t. TPI and NPI of the billing provider (Box 33a and 33b)

Primary insurance EOP must be attached, if applicable or claim will be

denied for this information.

Claims for Community First should be billed with the normal fees you would charge in the absence of a contract with a health plan. Community First will make the appropriate adjustments per its contract with you, if necessary, and will show any adjustments made on the Explanation of Payment sent to you with your reimbursement check.

Community First will provide the provider at least 90 days notice prior to implementing a change in the above referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

2. Hospitals and Other Facilities

Hospitals, Rural Health Centers and Home Health Nursing Charges must be filed on a **UB-04 (Exhibit 11)** with the following information:

- a. Name and address of the facility providing the service (Field 1)
- b. Patient Control Number (Field 3)
- c. Type of Bill (Field 4)
- d. Tax ID Number of the facility providing the service (Field 5)
- e. Coverage period (Field 6)
- f. Member's name and address (Field 12 & 13)
- g. Patient's DOB, sex, MS (Field 14, 15, 16)
- h. Admission date and hour of admission and discharge (Box 17, 18, 19, 20)
- i. Discharge status (Box 22)
- j. Value codes (Fields 39, 40, 41)
- k. Three digit Revenue Code (Box 42)
- l. Description (Field 43)
- m. HCPCS codes (Box 44)
- n. Date of service (Box 45)

- o. Number of units (Box 46);
- p. Billed charge for each revenue code (Field 47);
- q. Payor (field 50)
- r. Provider Number (field 51)
- s. National Provider Identifier (NPI) (Field 56)
- t. Insured's Name (Field 58, 59)
- u. Patient's Plan ID Number (Field 60)
- v. Authorization number, if applicable (Field 63)
- w. ICD-9 Diagnostic code(s) (Field 66-68)
- x. Attending physician Provider name and NPI (Box 76)
- y. Operating physicians NPI, if applicable (Box 77)

Note: Only claims including all required information are considered clean claims.

Community First will provide the Provider at least 90 days notice prior to implementing a change in the above referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

C. Claims Submission

Community First receives a significant number of paper claims on a monthly basis. Our goal is to process your claims as quickly as possible. To expedite claim processing we are asking your assistance with the following:

1. Submit paper claims through normal mail delivery **unless** you are in jeopardy of missing the filing deadline and you require proof of timely filing.
2. Use 10"X13" envelopes; send multiple claims in one envelope
3. Do not staple, paper clip or fold claim forms or attachments
4. Do not use red ink.
5. Claims must be legible and readable. Handwritten claims are difficult to scan.

If you would like information on submitting your claims electronically, contact Availity, our vendor for electronic filing at (800-282-4548). If you need additional information on electronic filing contact your network management representative

D. Electronic Data Interface (EDI)

Community First can now accept all professional and institutional claims through Electronic Data Interface (EDI), which is the preferred method of receipt. Community First uses the health care clearinghouses Availity and the SSI Group as its intermediaries.

Please follow the following processes when submitting EDI claims:

1. The preferred method of receipt of claims is electronically through EDI. Community First uses Availity as the intermediary.
2. The Community First **Payor ID** is **COMMF**
 - a. The Availity **Receiver Type** is **F**
 - b. If submitting claims electronically, Availity will either accept or reject the claims.
 - c. You will receive a response report within 24 hours after a successful transmission. The report will indicate the claims that were accepted and the claims that were rejected. **The rejection information on the response report is the only notification you will receive that the claim was rejected and why.** It is imperative that you read and understand the response report.
 - d. Availity reference guide detailing the specifics of submission is available by calling 1-972-766-5480.

As of October 16, 2003, health plans and providers who submit any claims electronically must comply with federal regulations adopted under HIPAA and governing the standardization of core health care transactions, including claims submission. Health care clearinghouses will also be required to comply with the regulations, and providers may comply through contracting with a clearinghouse to ensure that standardized information is submitted to Community First. As Community First implements this regulation and modifies its own processes, it will provide you notice of how such modifications affect the claims submission process.

Community First must notify Providers in writing of any changes in the list of claims processing or adjudication entities at least 30 days prior to the effective date of the change. If Community First is unable to provide 30 days notice, Community First

must give the providers a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

Community First shall adjudicate (finalize as paid or denied adjudicated) clean claims within 30 days from the date the claim is received by Community First. Community First will pay providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within 30 days.

E. Services included in the Monthly Capitation

For more information or questions, please contact Community First Health Plans at (210) 358-6000.

F. Emergency Services Claims

Community First's policies and procedures, Covered Services, claims adjudication methodology and reimbursement levels for Emergency Services comply with all applicable state and federal laws, rules and regulations including 42 C.F.R. 438.114, whether the provider is a participating network provider or Out-of-Network. Community First's policies and procedures are consistent with prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the contract with HHSC and C.F.R. 438.114.

Community First will pay for the professional, facility and ancillary services that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting as an Emergency Medical Condition or an Emergency Behavioral Health Condition to a hospital emergency department, 24 hours a day, 7 days a week, rendered by either a Participating Provider or an Out-of-Network provider.

Community First does not require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. Nor does Community First hold the Member liable for the payment of subsequent screening and treatment to diagnose the specific condition or stabilize the Member who had an Emergency Medical Condition.

G. Cost Sharing Schedule

Each CHIP family is designated a preset out-of-pocket spending limit by Texas Access Alliance. These out-of-pocket costs are comprised of co-payments made for services. Once this preset limit has been satisfied, the CHIP family will be absolved of financial responsibility for the remainder of the contract year. **(Exhibit 12)**

H. Billing Members

By entering into an Agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services rendered to Members. By contract ***you cannot bill Members for the difference between your normal charge and the payment rate that you negotiated with Community First for rendering covered services.***

You have also agreed that in no event, including, but not limited to nonpayment by Community First or our insolvency or breach of our agreement with you, will you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, the State of Texas, or any persons other than us for services provided pursuant to your agreement with Community First.

Community First will initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Network Provider from collecting allowable copayment and deductible amounts from CHIP Members

Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Network Provider contract

In addition, you may not bill a Member if any of the following circumstances occur:

1. Failure to submit a claim, including claims not received by Community First.
2. Failure to submit a claim to Community First for initial processing within the 95 day filing deadline.
3. Failure to submit a corrected claim within the 180 day filing re-submission period.
4. Failure to appeal a claim within the 180 -day appeal period.

I. Time Limit for Submission of Claims/Encounter Data/Claims Appeals

1. Filing Deadlines:
 - a. Community First must receive clean claims for CHIP services within ninety-five (95) days of the date of service.
 - b. Claims received after the filing deadline will be denied payment.

2. Proof of Timely Filing:

Community First **accepts the following as proof of timely filing:**

- a. Certified mail receipt
- b. Dated fax transmission confirmation with Community First's fax number
- c. Electronic confirmation from Availity
- d. Log listing claims with member name and date of service if signed by both the provider and a Community First representative.

3. Appeal Deadlines:

- a. Providers have the right to appeal the denial of a claim by Community First. Community First **CHIP Claim Appeal Submission Form (Exhibit 13)** must be received by Community First within ninety-five (95) days of the date of the **ORIGINAL** Explanation of Payment.
- b. All appeals and or corrected claims must indicate such on the claim. Community First will not accept an appeal submitted after the appeal deadline.
- c. Resubmission of a claim without correcting the claim is not considered an appeal.
- d. Methods available to appeal a claim are:
 - i. Telephonically through the Claims Customer Service center at (210) 358-6200.
 - ii. In writing to Community First to:

Community First Health Plans, Inc.
Attn.: Claims Appeal
4801 NW Loop 410, Suite 1000
San Antonio, Texas 78229

Effective April 3, 2009 report to new address below:
Community First Health Plans Inc.
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

- iii. In writing through your Network Management Representative.
- iv. In writing through HSM Department, if related to a notification or authorization issue.
- v. Fax to **210-358-6199, Attention Claims Appeal.**

*In the event of a natural disaster please contact Community First within 10 days if filing deadlines cannot be reached.

J. Negative Balances

- 1. Community First has the right to recover overpayments made to providers
- 2. If a negative balance exists on an EOP, maintain a copy of the EOP for future reference.

K. Coordination of Benefits

Coordination of Benefits is not included in the CHIP Program.

L. Third Party Recovery

Provider understands and agrees that it may not interfere with or place any liens upon the state's right or Community First's right, acting as the state's agent, to recovery from third party resources

M. Explanation of Payment (EOP)

- 1. You will receive an **Explanation of Payment Form (Exhibit 14)** detailing:
 - a. Date of Service
 - b. Place of Service (LC)
 - c. Diagnosis code
 - d. Procedure code
 - e. Modifier
 - f. TOS
 - g. Days/count
 - h. Amount billed;

- i. Allowed (contracted) amount;
 - j. Deductible/Copay amount
 - k. Other insurance payment (TPP);
 - l. Amount Denied
 - m. Total benefit paid to the provider.
 - n. Reason/s for denial or nonpayment (Explain codes)
2. It is imperative that you review your EOP to determine the reason or reasons for the denial. If you do not review your EOP you will jeopardize your opportunity for appeal.
 3. If negative services balance exists on the EOP, maintain a copy for future reference.
 4. The address page of the EOP will also be used for messages to providers that are of significance for claims submission and payment.

N. EOP, Duplicate Checks and Cancelled Check Requests

Community First receives a significant number of requests each month from providers for additional copies of EOPs and canceled checks. The provider is sent a copy of the EOP with each check issued by Community First. It is the responsibility of each provider's office to keep this information available for use in posting payments and submitting appeals. We recommend that a copy of the check, both front and back, as well as a copy of the EOP, be made by your practice so you have it available should you need in the future.

Check printing errors that result in duplicated checks should be reported to Community First Health Plans as soon as identified. Provider assumes responsibility for keeping an accurate record of checks received to ensure that a duplicate check is not deposited or cashed. Any bank fees that provider accrues after provider deposits or cashing a duplicate check will not be reimbursed by Community First Health Plans.

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of \$15.00 per EOP and \$20.00 per check.

The request for a copy of the EOP and/or check must be submitted in writing

along with the appropriate fee. The request must include the date of the EOP, the name of provider, and date of the check. Send the request to:

Community First Health Plans
4801 NW Loop 410, Suite 1000
San Antonio, Texas 78229

Effective April 3, 2009 report to new address below:

Community First Health Plans Inc.
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

O. IntelliClaim

All physician and provider claims submitted to Community First for adjudication on or about November 8, 2004 will be audited by Intel Claim as part of the claims adjudication process.

The analysis by Intel Claim is based on procedure rules and coding schemes developed by the AMA and found in CPT-4 & ICD-9 manuals as they apply to medicine, surgery, radiology, laboratory, pathology and anesthesiology services. Many other resources also were used by IntelliClaim to develop the auditing system such as CCI (Correct Coding Initiative), CMS, specialty societies and specialty consultants. IntelliClaim is updated by its developers annually as new editions of CPT & ICD manuals become available.

IntelliClaim provides consistent and objective claim review. Some of the common oversights IntelliClaim will identify are:

1. Mutually exclusive procedures
2. Incidental procedures
3. Medical visits, same date of service
4. Bilateral or Duplicate procedures
5. Pre and Post-Operative Care unbundling
6. Single code conflicts
7. Assistant surgeon conflicts
8. Procedures bundling

XIV. CHIP MEMBER ENROLLMENT AND DISENROLLMENT

A. Enrollment is 12 months eligibility.

To enroll in Community First's health plan, the Member's permanent residence must be located within Community First's service area. TexCare will electronically transmit to Community First new Member information, PCP selections, and change information applicable to active Members five business days prior to the first day of each month. **Twelve months of continuous coverage begins on the first day of the month following enrollment unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month.**

Enrollment Waiting Period. Most families will have to wait three-months before their children can use CHIP benefits. If the family meets one of the exceptions to the enrollment waiting period their children will not have to wait the three-months. Families who complete the renewal process on time and their children remain eligible for CHIP will not have to wait three-months.

Income Deductions No Longer Allowed. Families will no longer be allowed to deduct from their income the costs for child care, child support payments or care for disabled adults. Income eligibility for CHIP will be based on family's gross income (before taxes and no income deductions.)

CHIP Assets Test. Many families must have assets less than \$5,000 for their children to qualify for CHIP. Some families will be asked for information about the amount of money they have in the bank and the value of their cars. Some cars will not be counted as an asset

B. Re-Enrollment

At the beginning of the fifth month of coverage, TexCare will send a note to the family outlining the next steps for renewal or continuation of coverage. TexCare will also send a notice to Community First regarding its Members and to a community-based outreach organization providing follow-up assistance in the Members' areas. To promote the continuity of care for children eligible for re-enrollment, Community First may facilitate re-enrollment through reminders to Members and other appropriate means. Failure of the family to respond to TexCare's renewal notice will result in disenrollment from Community First and from CHIP.

C. Dis-Enrollment

1. CHIP Member's can be disenrolled from CHIP for any of the following reasons:
 - a. "Aging-out" when a child turns nineteen

- b. Failure to re-enroll at the conclusion of the 12-month eligibility period
 - c. Change in health insurance status, such as a child enrolling in an employer-sponsored health plan
 - d. Failure to meet monthly cost sharing obligation
 - e. Death of a child
 - f. The child permanently moves out of the state or out of Community First's service area
 - g. Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP
 - h. Immigration
 - i. Good cause transfer
 - j. Increased income
 - k. Provisional eligibility term
 - l. Health plan change
 - m. Duplicate account
 - n. Not CHIP eligible
 - o. Already a member
 - p. Child left household
 - q. ERS (Skip)
 - r. Pregnancy – Teenager
 - s. Enrolled in Medicaid prior to CHIP enrollment
2. Community First has the limited right to request disenrollment of CHIP Members from our health plan. The CHIP Member may request the right to appeal such decision. The PCP will be responsible for directing the CHIP Member's care until the disenrollment is made. Requests to disenroll a Community First CHIP Member *is acceptable* under the following circumstances:

- a. CHIP Member misuses or lends their Community First membership ID Card to another person to obtain services.
 - b. The CHIP Member is disruptive, unruly, threatening or uncooperative to the extent that the CHIP Member seriously impairs Community First's or a provider's ability to service the CHIP Member. However, this only occurs if the CHIP Member's behavior is not due to a physical or behavioral health condition.
 - c. The CHIP Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First to arrange for the treatment of the underlying medical condition.
3. Community First CHIP providers cannot take retaliatory action against members a member who disenroll from the Health Plan

D. Plan Changes

1. Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause.
2. HHSC will make the final decision.

XV. CHIP SPECIAL ACCESS REQUIREMENTS

A. Interpreter/Translation Services

Community First strives to be a culturally-sensitive organization and culturally-sensitive organization and has linguistic and interpreter services available for its CHIP Members to ensure effective communication regarding treatment, medical history or health education. These interpreter services are available on an "on-call" basis. Our contracted interpreter services provide Community First CHIP Members access to professionals trained to help with technical, medical or treatment information when a family member or friend interpreter is inappropriate. To arrange for a sign interpreter or language interpreter for a Community First CHIP Member, please contact Community First's CHIP Member Services Department at **210-358-6300**.

Community First also provides education related to the linguistic and cultural needs and characteristics of CHIP Members upon request from Community First participating providers.

B. Community First/ Provider Coordination

Community First and CHIP providers should make reasonable efforts to accommodate CHIP members with special access requirements.

C. Reading/Grade Level Consideration

Community First publishes Member information at a sixth grade reading level so that it can be easily interpreted by the CHIP member.

D. Cultural Sensitivity

Community First ensures persons with limited English proficiency have equal access to medical services to which they are legally entitled.

XVII. UTILIZATION MANAGEMENT

A. Overview

Community First's Utilization Management program determines whether proposed or rendered medical services and/or supplies are medically necessary and appropriate, are of a generally acceptable high quality and appropriate frequency, done in the appropriate setting and covered in the CHIP Member's benefit plan. Program components include preauthorization, concurrent stay review, discharge planning, retrospective review, disease management, and case management.

Note: These determinations only affect payment for services by Community First. The decision to provide treatment is between the CHIP Member and the attending physician.

Besides processing requests for authorizations, Utilization Management analyzes utilization patterns, and provides an appeal process to address disputes in a timely manner (Refer to Appeal section of this manual).

All reimbursement is subject to eligibility and contractual provisions and limitations.

Successful operation of our Utilization Management program depends upon your cooperation by:

1. Accepting and returning our phone calls concerning our CHIP Members;
2. Allowing us to review medical and financial records concerning care rendered to our CHIP Members;
3. Participating with us in discharge planning, disease management, and case management;
4. Participating with our Community First committee proceedings when appropriate.

B. Preauthorization

Community First currently requires preauthorization for the services listed in. The list of services requiring preauthorization is subject to change Community First will provide at least 90 days notice of changes in the list of authorized services.(Get updated auth list)

Note: Community First must give preauthorization before the patient's admission to a facility or visit to a specialty care provider for any service indicated. Preauthorizations are valid for 30 days from the date issued, unless a longer time frame is prearranged. Hospital confinements and inpatient or outpatient surgeries are valid only for the requested and approved days. If preauthorization expires, call Community First. All services listed on the preauthorization list (Exhibit 15) will be subject to medical necessity review in advance of the services being rendered. Failure to obtain preauthorization in advance of the service being rendered will result in an administrative denial of the claim, and providers cannot bill CHIP Members for covered services. Community First will not honor retro-active requests for authorization.

PCPs and specialists can call our Health Services Management Department at **(210) 358-6050** to obtain preauthorization, or fax the completed **Texas Referral/Authorization form (Exhibit 21)** to **(210) 358-6040**. The Health Services Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. CST. After hours and on weekends or holidays Community First accepts either your fax or phone message as meeting notification requirements, however, the services listed on the preauthorization list will need to be preauthorized by calling Community First to obtain an authorization number.

Please have the following information available when requesting preauthorization:

1. Member's name and ID Number
2. Primary diagnosis with ICD-9 Code, if known
3. Surgery/Procedure with CPT Code, or purpose and number of visits
4. Anticipated date of service or admission date
5. Name of consultant/facility
6. Expected length of stay (inpatient only)
7. Applicable NDC numbers

Community First's Health Services Management Department will issue an authorization number for approved requests. Faxed requests will be faxed back to the

requesting provider including the authorization number. Telephone requests will receive an authorization telephonically.

If a request is pended because information is incomplete, the provider will be contacted. Once we receive the required information, we will either approve the request or send the information to the Community First Medical Director for final review. If we do not receive the required information, the services will be denied.

Community First will deny requests that do not meet eligibility and/or benefit criteria, and notify the provider by phone and letter, either by fax or mail, within 48 hours. The CHIP Member is sent a denial letter by mail.

C. Referrals

The PCP or specialist may directly refer a member for services that do not require preauthorization. All referrals must be to a Community First network provider. Community First's provider network may occasionally change. Contact the Network Management Department at **(210) 358-6030** for current provider information. Use of a non-participating provider requires preauthorization by Community First. Specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations to ensure the Member's continuity and quality of care.

All referrals must be to a Community First network provider. Use of a non-participating provider requires preauthorization by Community First's Health Service Management Department. Referrals to a non-participating provider without the required preauthorization will result in denial of that provider's claim.

Referral notifications are valid for the number of visits requested. The PCP or specialist should contact Community First's Health Services Management Department to extend the referral past the original number of visits, or to request additional care or treatment prior to rendering additional care or treatment.

We do not require referral notification for routine lab or x-ray when a network provider is used.

Community First does not require preauthorization for court mandated inpatient psychiatric care for CHIP Members.

Note: Payment for services requiring notification or preauthorization is contingent upon current eligibility and applicable contract specifications at the time of service. For eligibility call (210) 358-6300.

D. Self-Referrals

CHIP Members may self refer for the following services:

- Obstetrical and/or Gynecological Services to a participating provider (except for those CHIP Members in a Limited Provider Network).
- Routine Vision for to a participating optometrist
- Emergency Care
- Behavioral Health Services

The PCP is encouraged to provide or coordinate referrals for the services shown above.

E. Private Pay Patients

Providers must advise clients that they are accepted as private pay patients at the time the service is provided and will be responsible for paying for all services received. In this situation, HHSC strongly encourages that notification be in writing with the patient's signature so there is no question how the patient was accepted. Without written, signed documentation that the Community First CHIP Member has been properly notified of the private pay status, the provider should not seek payment from an eligible Community First CHIP Member. A provider cannot bill a Community First CHIP Member for those reasons provided in the **Member Acknowledgement Statement (Exhibit 22)**. You should also include a copy of Community First Member's acknowledgement that they are a private pay patient.

F. Quality Management Improvement Program/Behavioral Health Medical Records

Community First's Quality Management and Improvement Program is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the healthcare delivery system. Components of this program include problem-focused studies, peer review, risk management, medical record review, ongoing monitoring of key indicators, and behavioral healthcare services evaluation.

XVII. CASE MANAGEMENT

A. Introduction

Community First is committed to providing the most appropriate and efficient level of service to our customers. Community First believes that case management is the cornerstone of managed care and is an essential component of Utilization Management. Through effective case management, communication is improved, thereby assuring that services are delivered at the appropriate level of care, maximizing use of all resources. Community First's Case Management

Program emphasizes the importance of communication between PCPs, specialists, and Community First.

Community First's Case Management Program or its designee, provides case management services to Community First CHIP Members. When a CHIP Member is identified or referred to Community First's Case Management staff, a needs assessment is conducted. Suggested criteria for referrals to the Case Management Program may include any combination of the following:

1. Frequent acute care admissions, more than 2 in six months;
2. Extended length of stay, more than seven days;
3. Non-compliance with medical regimen;
4. Knowledge deficit related to health care;
5. Multiple active chronic diseases;
6. Frequent emergency room visits, more than 2 in six months;
7. Ineffective coping;
8. Lack of/or burnout of care giver/support;
9. Multiple service use (i.e., a combination of physical, occupational and speech therapy);
10. Significantly impaired in activities of daily living; and
11. Complex cases requiring extensive (>3 hours) discharge planning.

Case management is initiated to assure appropriate utilization and timely delivery of quality health care for CHIP Members. Community First offers case management services for an individualized plan of health care, as well as targeted disease management programs for high utilization diagnoses. The purpose of case management is to promote the efficient and effective utilization of resources while assuring continuity and quality of care. All services are provided under the direction of the CHIP Member's PCP. Some case management candidates are initiated through a review of Community First's utilization data.

B. The functions of the Case Management Program are to:

1. Identify appropriate candidates for case management services based on high-risk criteria (i.e., co-morbid illnesses, chronic illness, catastrophic diagnosis, no family support, etc.).

2. Develop, coordinate and implement cost effective care plans for those CHIP Members identified to be appropriate candidates.
3. Serve as an advocate to coordinate and optimally utilize health care and community related services for the CHIP Member.
4. Inform health care professionals, CHIP Members, and their families of available community services.
5. Assist in the coordination of care with health care disciplines to promote the highest possible level of physical, psychological and social functioning for the CHIP member and family.
6. Identify aberrant practices and submit to the appropriate personnel.
7. Explain benefit coverage to CHIP Member and families.
8. Facilitate linkages to appropriate community resources.

Community First's Case Managers will work with the PCP and multidisciplinary team to facilitate the care plan. The Case Manager will request annual updates to ensure that the member needs are being met.

C. Case Management for Children with Complex Special Health Care Needs

Community First CHIP eligible children with complex special health care needs (CCSHCN) have access to enhanced care coordination. CCSHCN are defined as children who meet the following state defined elements:

1. Have serious ongoing illness, a complex chronic condition, or disability that has lasted or is anticipated to last at least twelve continuous months or more
2. Have an illness, condition or disability that results or without treatment would be expected to result in limitation of function, activities, or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development
3. Require regular, ongoing therapeutic intervention and evaluations by appropriately trained health care personnel
4. Have a need for health and/or related services at a level significantly above the usual for the child's age

A child, a child's family, a health care provider, the CHIP Administrative Services Contractor, or Community First may preliminarily identify a CCSHCN. Community

First will outreach to the Member to confirm the designation of and offer case management services.

CCSHCN are eligible for enhanced case management services inclusive of contacting the child's family to discuss covered services, including specialty services, the possibility of selecting a specialist as a primary care provider, out of network services applicable to the child's condition, enhanced care coordination, and community referrals.

The PCP is encouraged to contact Health Services Management to make a referral for any child that is considered to be a CCSHCN. Health Services Management contact can be by phone or faxed on the standard referral form.

XVIII. Preventive Health and Disease Management

Members who feel empowered to become knowledgeable partners in their health care are better able to accept responsibility for appropriate utilization of health care resources. With that in mind, Community First has developed programs, which work within the continuum of health to promote health, primary prevention, early detection and treatment, and disease management. Our goal is to promote a collaborate relationship between our members and their health care providers, to create a supportive environment for the development and maintenance of healthy lifestyle behaviors.

A. Provider Referral

Network providers are encouraged to inform Members about the health education services available through Community First. When an education or social need is identified, one can refer a Member to the Health Promotion & Wellness Department one of four ways:

1. Mail in the **Member Education Request Form (Exhibit 17)** to:

**Community First Health Plans, Inc.
Network Management
4801 NW Loop 410, Suite 1000
San Antonio, TX 78229**

**Effective April 3, 2009 report to new address below:
Community First Health Plans Inc.
Network Management
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249**

2. Fax the Member Education Request Form to (210) 358-6199.
3. Contact a Community First Health Educator at (210) 358-6144.

4. The standard Authorization form for Community First may also be completed and mailed in or faxed to request Health Promotion outreach.

B. Health Education Services

Health education is available through classes, educational mail outs and individualized outreach visits. Several initiatives been developed to educate members and promote involvement in self-care behaviors. Participation in disease management and health promotion initiatives is free-of-charge. Overall program goals include increased education regarding disease processes and management, establishment of a collaborative physician-patient relationship, appropriate utilization of health care resources, increased quality of life and member satisfaction and retention. Program participation information is routinely mailed to the primary care physician for review and inclusion in the member's medical record.



1. Diabetes Disease Management

According to prevalence studies conducted across the nation, diabetes affects over 16 million Americans and is the seventh leading cause of death in the United States. Most of the morbidity and mortality of diabetes is due to complications associated with the disease. Despite the existence of significant advancements in the treatment of diabetes, studies reveal that many secondary preventive care measures and tests are not applied in the outpatient setting.

In July 1998, planning meetings for the Texas Diabetes Care Pilot Program began, with the program implementation beginning February 1999. Community First participated in the pilot and then took the initiative to develop outreach mechanisms not only for the STAR population, but to include the CHIP and Commercial membership. Community First developed a diabetes disease management program, *Diabetes In Control*, which is accessible to our entire membership, to promote a collaborative approach to diabetes self management. The goals of the program include identification of members with diabetes, increase awareness and understanding of diabetes, increase risk reduction behaviors, improve access to quality diabetes education and health care services, and to promote diabetes standards of care, in coordination with the Texas Diabetes Council's Minimum Standards for Diabetes Care in Texas.

Members are identified via pharmacy management records, claims and encounter utilization data with a primary diagnosis of the disease state being managed, diabetes 250xx, physician referral, case management/utilization management /health promotion/member services, referrals and information gathered through self-reported member disclosure via health assessments. Case Managers screen members for possible referrals to the current *Diabetes In Control* programs by reviewing claims histories.

Members enrolled in the *Diabetes in Control* program, receive ongoing information on: controlling blood sugar; tips for talking to the doctor; routine diabetes screening tests; the member's role in preventing complications; blood sugar testing and supplies; and self-management during an illness. Members are eligible to attend community-based diabetes education classes. Higher risk members are referred to one-on-one intensive education, which provides education on the importance of regular checkups; checking blood sugars at home; exercising regularly; following a meal plan; taking necessary medication; maintaining recommended weight; taking care of skin and feet; and management of their diabetes in conjunction with other current acute or chronic conditions. Because depression is a well-documented component of this chronic condition, potential behavioral health needs are taken into consideration and incorporated into the plan of care.



2. Asthma Disease Management

AsthmaMatters is an initiative developed by Community First to improve the health, well-being and productivity of our members with asthma. Through ongoing review and oversight of this comprehensive disease management program, Community First works to provide quality health promotion and education services, in collaboration with our members, providers and community organizations. A key element of the program is to promote the development of a strong collaborative relationship between our members and their primary care providers and the use of nationally accepted care standards for asthma, to help members achieve long term control of their disease, which will result in the appropriate utilization of health care services.

The *AsthmaMatters* program targets members identified to have asthma, via pharmacy management records, claim and encounter utilization data, and information received via the completion of member health surveys.

Routinely, utilization patterns are assessed and targeted intervention is implemented to coordinate health care delivery and measures to improve members' clinical, humanistic and economic status. Clinical outcomes may include a decrease in the use of beta-agonists, an increase in use of asthma controlling medications and an increase in the number of outpatient visits. Humanistic outcomes may include an improvement in quality of life factors (increased productivity and activity without asthma episodes, decreased absences from work or school, sleeping through the night without asthma episodes), increased knowledge about the disease, and overall asthma control with a decrease in acute asthma episodes. Economic outcome measures include decreased hospital admissions and emergency room events and/or unscheduled visits.

Upon identification of prospective members, steps are taken to assess asthma severity levels and implement appropriate education and outreach services for each member. Prospective AsthmaMatters members are sent an asthma health risk appraisal form. Key areas assessed include current symptoms, treatment protocols and perception of quality of life. Upon receipt of the survey, members are stratified into one of three risk categories: minimal, mild to moderate, and higher risk. For each risk category, health promotion outreach activities include:

- a. Minimal Risk Send education literature each bi-monthly
- b. Mild to Moderate Risk Send education literature each bi-monthly
 - Provide peak flow meter and OptiChamber kit
 - Follow-up call / Recommend asthma class
- c. Higher Risk Send education literature each bimonthly
 - Refer to Case Management for further evaluation
 - Possible health assessment and education

Asthma education is coordinated with existing community education programs, to promote utilization of services currently available. Members who are categorized in the mild to moderate risk category are mailed a roster of up-to-date classes available in the community. Follow-up calls are conducted for members who continue to accrue inappropriate utilization of the emergency room and/or hospitalization, to assess for possible barriers to care and compliance.

Members who require intensive assessment and education are referred to asthma disease management education. Education is provided on an individualized basis, over several visits, to promote member control and

knowledge about their disease. The home environment is assessed and recommendations are given to decrease the risk of an acute asthma episode.

Our goal is to provide programs, which encourage our members to actively participate in their asthma management, in collaboration with their physician. As part of the initiative, the primary care physician receives a copy of the members' health assessment tool, with a summary of the assigned risk status and educational outreach Community First has initiated for each member. Information regarding home assessment and education is also sent to the primary care provider, for inclusion in the medical record. Providers whose patients are stratified as high-risk through utilization data, receive utilization and pharmacy profiles for inclusion in member's medical record.



3. Prenatal Education Program

According to the March of Dimes, nearly four million babies are born in the United States each year, with over 500,000 (13%) being born to teenage mothers. More than a quarter of a million babies (7%) are low birth weight (defined as less than 2500 grams or 5.5 pounds), while 53,000 (1.3%) are very low birth weight (defined as less than 1500 grams or 3.3 pounds). More than 430,000 (11%) are preterm births.

The percentage of women seeking and obtaining prenatal care during the first trimester has increased over the years. Many high-risk women, however, continue to experience difficulty in accessing early prenatal care. The Texas Department of Health, Bureau of Vital Statistics, reports that in 1997, 15.4% of pregnant women in Region 8 (twenty-eight county area of South Central Texas) received late or no prenatal care. This is of particular concern for the pregnant teen, as 16.7% of all live births in Bexar County in 1996 were to young women under the age of 20 (7.5% were to girls between 10 and 17 years of age). This is significantly higher than the 13.1% national figure.

Access to early prenatal care is a hallmark of quality health care. Community First has worked with the Health and Human Services Commission and STAR health plans across the state to expedite the Medicaid eligibility determination and the enrollment of pregnant women into Medicaid managed care, as directed by House Bill 2896, 76th Legislative Session. As a result, Medicaid eligibility was simplified and a process is now in place to expedite enrollment within 30 days of application. Health plans receive the names of newly enrolled members on a daily basis, to

promote immediate access to prenatal care.

Community First Health Services Staff outreach to 100% of newly enrolled Medicaid members. Successful contact has increased from 35% in August 2000 to 75% in August 2002. Barriers to contact across the state include inaccurate telephone numbers and addresses. Community First remains committed to continual improvement in outreach efforts to the prenatal population.

The Health Services Staff collaborate with health plan providers to offer comprehensive perinatal services, as we believe education is an important factor in changing behaviors and improving the overall health of our members. Outreach to pregnant members includes:

- a. completion of a prenatal health risk assessment;
- b. referral to educational or community resources, as needed;
- c. education regarding the importance of early prenatal care;
- d. assignment of a pediatrician prior to birth and newborn check-ups;
and
- e. education regarding the importance of the 6 week postpartum visit.

Community First is committed to addressing these issues at large, through our *Healthy Expectations* prenatal program, because of the opportunity for a “win-win” situation. Health outcomes can be improved, at the same time that the high costs of perinatal care can be reduced. The *Healthy Expectations* program utilizes two phases to outreach and educate prenatal members.

An assessment program for identified pregnant women provides opportunity to identify risk factors. Social and behavioral health education and referral are typical outcome strategies at the initial assessment phase. When completed, the risk tool allows clinical staff time to outreach to those at increased risk for complications. Those at lower risk are sent educational materials by mail and encouraged to attend community sponsored prenatal education classes. Pregnant members are routinely reassessed at 20-24 weeks gestation, to evaluate for changes in prenatal health.

A high-risk component to the prenatal program allows clinical staff an avenue for conducting ongoing education and outreach to women at a higher risk for adverse pregnancy outcomes. This component of the program was initiated November 1999, and is intended to provide education and assistance to our members who are at risk for experiencing

pregnancy complications, especially premature labor. Registered nurses, who have an obstetric care nursing background, provide education and assistance in coordination of necessary services.

The phases of the *Healthy Expectations* prenatal program provide numerous opportunities to assess member health, pregnancy status, to promote compliance with appropriate perinatal guidelines, and provide member education. Programs such as our *Healthy Expectations* have been recognized by the American Association of Health Plans as best practices in case management for prenatal care. Academic research and experience by other health plans have demonstrated a decrease in the costs of newborn care, mostly due to the prevention of premature births.

4. Children with Complex Special Health Care Needs (CCSHCN) Program

In the past several years, Community First has worked with the Texas Department of Health and the Center for Health Care Strategies, to identify children with complex special health care needs. If a member with a complex special health care need is identified, clinical staff is available to assess health care needs of the member and assist in accessing health care services needed. Outreach mechanisms have been developed to assess members' physical, developmental, behavioral, and/or emotional health conditions and the need for care coordination and case management services.

Community First staff is available to outreach to CHIP members at the physician's request, to detect health risk factors, assess potential participation in population-based initiatives or disease management programs and to assess barriers to care. An individualized care plan will be initiated for each member who accepts case management services. Educational information and resource information is given to members, including social services resources. Although not all social concerns are directly related to their medical care, frequently these issues affect access to care, continuity of care and compliance with treatment plan. Community First works to assist members in addressing these concerns to promote wellness. Information gathered from the member is forwarded to the primary care physician for review, potential outreach and inclusion in the medical record.

In 2002, Community First conducted a survey of primary care provider needs regarding care coordination, access to Community First's case management services, community-based services and federal/state benefit programs. Physicians verbalized interest in having a standard care plan, which can be individualized for each patient. A care plan has been developed and is included as **Children with Complex Special Health Care Needs Form (Exhibit 16)**.

If you are caring for a child with special health care needs and would like assistance in coordinating a multi-disciplinary care plan or case management services, please fax your referral to the Utilization Management department at 358-6040.

XIX APPEALS

A. Adverse Determination

If you wish to appeal a decision made by Community First that the health care services proposed to be furnished or furnished to a CHIP Member are not medically necessary, you or the CHIP Member may appeal the Adverse Determination orally or in writing.

Please adhere to the following process when appealing an Adverse Determination:

1. Within five (5) working days from receipt of the appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the appeal. This letter will include a reasonable list of documents needed to be submitted to Community First for the appeal.
2. When Community First receives an oral appeal of adverse determination, Community First will send the appealing party a one-page appeal form.
3. Emergency care denials, denials for care of life-threatening conditions, and denials of continued stays for hospitalized patients may follow an expedited appeal procedure. This procedure will include a review by a health care provider who has not previously reviewed the case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

The time frame in which such an expedited appeal must be completed will be based on the medical immediacy of the condition, procedure, or treatment, but not to exceed (1) working day following the date that the appeal, including all necessary information to complete the appeal, is made to Community First.

4. After Community First has reviewed the appeal of the Adverse Determination, Community First will provide written notification to the CHIP Member, and the CHIP Member's physician or health care provider explaining the resolution of the appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than (30) days after we receive the written appeal or completed appeal form. The notification will include:

- a. A clear and concise statement of the specific medical or contractual reason for the resolution.
- b. The clinical basis for such decision.
- c. The specialty of any physician or other provider consultant.
- d. If the appeal is denied, the written notification will include notice of the appealing party's right to seek a review through a Independent Review Organization (IRO) (See Member Complaints and Appeals section).
- e. Denials for care of life threatening conditions can be appealed directly to the Independent Review Organization as outlined in the denial letter.

Please be informed that you have the right, at any time, to contact the Texas Department of Insurance at 1-800-252-3439.

Please Note: This decision affects coverage only, and does not control whether to render medical services.

B. Appeals of "For Cause" Termination of HMO Agreement

According to your agreement with Community First, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If we give you a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure. This procedure is available only if we are terminating your agreement for the reasons stated above.

1. Notice of Proposed Action

Community First will give you notice that your agreement has terminated or is about to terminate, and the reason(s) for the termination. The notice will either accompany your sixty (60) day notice of termination, or be given at the time your agreement terminates immediately without notice.

Upon termination of your agreement, you may file an appeal with Community First's Medical Director by registered or certified mail within thirty (30) days of receiving the notice of termination. You should include any explanation or other information with your request for appeal. Community First's Medical Director will appoint a committee to review your request and any additional information or explanation provided

within thirty (30) days of receipt. The committee will make a recommendation to the Board of Directors of Community First to reaffirm your agreement, or reaffirm your agreement with sanctions or uphold your termination.

2. Decision

Within ten (10) days of the Board of Directors decision, Community First will, by registered or certified mail, inform you of Community First’s Board of Directors decision on your request for appeal. This decision will be final.

XX OTHER

A. Member Copayments

| Federal Level Of Poverty | Office Visits | ER Visits | Inpatient Stay (per admission) | Generic Drugs | Brand Drugs | Annual Reporting Caps |
|--------------------------|---------------|-----------|--------------------------------|---------------|-------------|--|
| Native Americans | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| At or below 100% | \$3 | \$3 | \$10 | \$0 | \$3 | 1.25% family annual gross income |
| 100%-150% | \$5 | \$5 | \$25 | \$0 | \$5 | 1.25% family annual gross income |
| 151%-185% | \$7 | \$50 | \$50 | \$5 | \$20 | 2.5% cap of family annual gross income |
| 186%-200% | \$10 | \$50 | \$100 | \$5 | \$20 | 2.5% cap of family annual gross income |

B. PCP Request for Member Transfer

The PCP must submit a request to Community First in writing to transfer a Community First CHIP Member from the PCP’s practice. Complete a Community First’s **Provider Request for Member Transfer form (Exhibit 18)** and return the completed form to your Community First Provider Relations Representative. If you have any questions regarding this process, please contact Community First’s Network Management Department at **210-358-6030**.

C. Member Request for PCP Change

A CHIP Member's parent or guardian may call Community First to request a change in PCP. If a CHIP Member requests a PCP change before the 15th day of the month, the change usually becomes effective on the first day of the following month. Changes received after the 15th day of the month usually becomes effective the first day of the second month following the change request.

D. Continuity of Care

Community First provides CHIP Members with a process to address continuity of care issues involving continuation/transition of ongoing care and to request the use of a specialist as their Primary Care Physician (PCP). This policy outlines the situations and describes the process for requesting this type of coverage.

Continuity of Care coverage can be approved for two different circumstances as outlined below:

1. Transition of Care
2. Specialty Care Provider (SCP) as PCP

E. Transition of Care involves any active course of treatment rendered by a non-participating specialist prior to a new CHIP Member's effective date and is expected to continue for 60 days following the effective date of the plan. An "active course of treatment" is one in which discontinuity would cause a recurrence or worsening of the conditions under treatment and interfere with anticipated outcomes (examples would be: post surgical care; illness recovery; or psychotherapy for an acute exacerbation; or chronic psychiatric condition).

F. Specialist as PCP coverage is designed to provide for the complex care needs associated with CHIP Members that have either disabilities or chronic/complex medical or behavioral conditions. Through collaboration with Community First nurse case managers, CHIP Members with disabilities or chronic/complex medical or behavioral conditions are encouraged to maintain a stable Medical Home (Primary Care Physician), with unduplicated services through the appropriate development of a care plan. In the certain qualifying situations, Community First may allow a participating specialist currently treating a CHIP Member with disabilities or chronic/complex conditions to serve in the capacity of the Medical Home.

PCPs and Specialists can call our Health Services Management Department at **210-358-6050** to address any continuity of care issues, or fax the **Request For Continuity of Care** form (**Exhibit 1**) to **210-358-6040**. Community First will coordinate with Texas Department of Protective and Regulatory Services (TDPRS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of TDPRS.

G. Release of Information

Provider must obtain a signed authorization for release of information from CHIP Members. You may use the standard CMS 1500/UB92 or develop your own form. If you develop your own form, the release should allow you to disclose information to Community First. This will enable us to process claims and perform our Utilization Management and Quality Management functions.

H. Member Privacy

As of April 14, 2003, both Community First and all providers in the Community First network will be required to comply with federal regulations adopted under the Health Insurance Portability and Accountability Act of 1996 and governing the privacy of individually identifiable health information. Through Senate Bill 11 passed during the 77th Legislative Session, Texas also substantially incorporated the HIPPA privacy regulations into Texas law, giving the state its own enforcement powers. Community First is enacting policies and processes to meet the compliance deadline and anticipate that the providers in its network are also taking steps to ensure compliance.

I. PCP Request to Change Panel Status

To change your Community First panel status, please notify Community First's Network Management Department in writing (via mail, fax or e-mail) of your request to either open or close your panel. *According to your agreement with Community First, you must notify Community First in writing at least sixty (60) days prior to any action by you to limit or close your panel to Community First CHIP Members. Notifications less than sixty (60) days to limit or close your panel will be considered on a case-by-case basis.*

J. Vendor Drug Program

Community First does not provide prescription drugs for CHIP Members. These drugs are covered by the CHIP Prescription Drug Benefit (PDB). Members can take their child's prescription to any pharmacy taking part in the CHIP PDB.

Members should take the child's Community First ID card with them when they go to the pharmacy. The pharmacy can make sure the Member's child is a CHIP member. The pharmacy may ask for the ID card. The member may have to pay a co-payment for the prescription. A prescription for a generic drug may cost nothing or cost very little. The co-payment for a brand name drug will be higher. The CHIP PDB does not offer drugs by mail order.

The CHIP PDB does not cover:

1. Over-the-counter drugs
2. Birth control medications prescribed only for birth control purposes

3. Nutritional products
4. Medical supplies or equipment, except for insulin syringes
5. Drugs that must be given in a physician's office or health care facility.

Call the Texas Access Alliance if you need help finding a pharmacy. Their number is 1-800-647-6558. Call the CHIP Prescription Hotline if you have problems getting prescriptions filled. Their number is 1-866-274-9154.

CHIP recipients are limited to 4 brand-name drugs per month or a 34-day supply of brand-name drugs.

K. Provider Under Investigation

Community First will not pay claims submitted for payment by a network provider who is under investigation, or has been excluded or suspended from the Medicare or Medicaid programs for fraud and abuse, when Community First has been notified of such investigation, exclusion or suspension.

L. Balance Billing Members

By entering into an Agreement with Community First, you have agreed to accept payment directly from us. Reimbursement from Community First constitutes payment in full for the services rendered to Members. By contract ***you cannot bill Members for the difference between your normal charge and the payment rate that you negotiated with Community First for rendering covered services.***

You have also agreed that in no event, including, but not limited to nonpayment by Community First or our insolvency or breach of our agreement with you, will you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, the State of Texas, or any persons other than us for services provided pursuant to your agreement with Community First.

In addition, you may not bill a Member if any of the following circumstances occur:

1. Failure to submit a claim, including claims not received by Community First.
2. Failure to submit a claim to Community First for initial processing within the 95 day filing deadline.
3. Failure to submit a corrected claim within the 95 day initial filing period.
4. Failure to appeal a claim within the 90 -day appeal period.

5. Failure to submit a request for preauthorization when applicable

M. Member Acknowledgement Statement

The provider obtains and keeps 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 the (dates of service) may not be covered under the Community First CHIP as being reasonable and medically necessary for my care. I understand that I am responsible for payment of the services or items I requested and receive if these services or items are determined not to be reasonable and medically necessary for my care."

N. Private Pay Form Agreement

The provider obtains and keeps a written Private Pay Form Agreement, signed by the member that states: "I understand _____ (Provider Name) _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying any services I receive. The provider will not bill a claim to Community First for Services provided to me."

O. CHIP Vaccine Program

Health and Human Service Commission (HHSC) will use the Centers for Disease Control and Prevention federal contracts to purchase vaccines at federal contract prices for provision to providers enrolled in CHIP. Vaccines not available on a federal contract will be purchased using a state contract price or using state purchasing procedures for vaccines not on a state contract. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the Advisory Committee on Immunization Practices (ACIP).

HHSC will purchase, store, and distribute vaccines purchased using the vaccine delivery system operated by HHSC. HHSC will monitor vaccine reports and track vaccine distribution to CHIP providers to assure an adequate inventory of vaccines for CHIP providers.

HHSC and the Texas Department of State Health Services will provide information and training, as necessary, to providers, health care plans, and parents of CHIP-eligible children regarding the CHIP vaccine program.

CHIP providers must complete and submit the vaccine accounting documents to HHSC. Documentation required tracks the requirements for the **Texas Vaccines for Children** Program with forms designated as "CHIP". (**Exhibit 20**)

Any providers who have not enrolled in the Texas Vaccine for Children Program may contact HHSC (512) 458-7284 or 1-800-252-9152. They will provide you with the location/telephone number of the local health department or regional office you

need to work with to become enrolled and receive the vaccine.

Community First must conduct two behavioral health focus studies annually. The focus studies have a standardized format, and will be conducted according to the criteria and methods developed by HHSC.

P. STD and HIV Testing and Reporting Procedures

1. Gonorrhea and Chlamydia Infection Testing

Gonorrhea and Chlamydia infections are the most common reportable sexually transmitted diseases in the United States today. For this reason, sexually active adolescents are tested for both of these diseases simultaneously. Untreated infections may result in severe complications, including sterility and pelvic inflammatory disease.

2. HIV Testing

It is critical to maintain confidentiality when caring for clients, as well as their specimens. Do not leave specimens identified for HIV testing in open view of unauthorized medical personnel. Discussions with clients regarding their risk factors should be confidential. Testing should be performed only after informed consent is obtained from the adolescent. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management and treatment providers; STD clinics; and other related service organizations at 1-800-299-2437. The toll-free service is available for English and Spanish speaking callers, and for those who are hearing-impaired. The Texas HIV/STD Community Resource Directory is available at www.tdh.state.tx.us/hivstd/commsvcs/default.htm.

HIV prevention counseling should be made available, which should include health guidance regarding responsible sexual behaviors, including abstinence. HIV prevention counseling should include the following:

- a. Counseling that abstinence from vaginal, oral and anal intercourse is the most effective way to prevent pregnancy, STDs and HIV infection.
- b. Counseling on how HIV infection is transmitted, the dangers of the disease, and the fact that using latex condoms reduces the risk of transmission of HIV and some STDs.

- c. Reinforcement of responsible sexual behavior for adolescents who are not sexually active currently and for those who use birth control and condoms appropriately.
- d. Counseling on the need to protect themselves and their partners from pregnancy, STDs, HIV infection, and sexual exploitation.

3. Sexual Behavior/ Sexually Transmitted Diseases (STDs)

Ask about involvement in sexual behaviors during a general screening.

- a. Adolescents who are sexually active should be asked about their use and motivation to use condoms or barrier methods and contraceptive methods, their sexual orientation, the number of sexual partners they have had, if they have exchanged sex for money or drugs, and their history of prior pregnancy or STDs.
- b. Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on how to reduce this risk.
- c. Adolescents who are sexually active should also be asked about their use of tobacco products, alcohol, and other drugs.

4. STD Screening Procedures for Sexually Active Adolescents

Sexually transmitted disease risk status includes the following:

- a. Having used injectable drugs.
- b. Having had sexually transmitted disease (STD) infections.
- c. Having had vaginal, anal, or oral sex.
- d. Having exchanged sex for drugs or money.
- e. Having had a sexual partner who is at risk for HIV infection (i.e., injectable drug use, past or present STD infection).

The provider will make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.

Q. Early Childhood Intervention (ECI) Services

Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). The provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting

R. Tuberculosis Services Provided by DSHS-approved providers

1. Community First providers must coordinate with the local TB control Program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy(DOT). The Providers must report to the Texas Department of State Health Services (DSHS) or may be posing a public health threat. **(Exhibit 6)**
2. Community First providers must coordinate with LTCHA and report any Community First CHIP Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.
3. Community First providers must ensure all procedures required to screen at-risk Members and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in Section 8.2.2.8 as Non-Capitated Services.
4. Community First providers must ensure that Members who may be or are at risk for exposure to TB are screened for TB. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions.
5. Community First providers must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and DSHS policies and standards.
6. Community First providers must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.
7. Community First Nurse Coordinators work with the servicing provider in coordinating a post-discharge plan for follow-up DOT with the local TB program. Community First in conjunction with the serving provider coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.