Bexar Service Area
September 2015

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

PROVIDER MANUAL

Provider Services Phone Numbers
(210) 358-6030
Toll Free 1-800 434-2347

Office Hours 8:30 a.m. to 5 p.m.
Monday thru Friday, except state-approved holidays

Website
WWW.CFHP.COM

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I. INTRODUCTION

A. Background and Objectives of Program

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

The Children's Health Insurance Program (CHIP) CHIP-Perinatal Service provides services to unborn children of non-Medicaid eligible women. Unborn children will be eligible from conception and once enrolled, they will receive 12 months of continuous eligibility. Our objective is to ensure that CHIP Perinatal 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 Perinatal 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 Health Plans' network provider with one of the following specialties: General Practice, Family Practice, Pediatrics or Internal Medicine.

> 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 Health Plans' 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 Health Plans' CHIP/CHIP-Perinatal 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 Health Plans will publish and distribute a quarterly newsletter to all network providers. The newsletter will include

information about Community First Health Plans' services, policies and procedures, and appropriate government statutes and regulations.

Community First Health Plans 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/CHIP-PERINATAL 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

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

From Outside Bexar County	1-800-434-2347
Health Services Management	(210) 358-6050
Preauthorization Fax	(210) 358-6040
Behavioral Health & Substance Abuse Services Crisis Hotline:	1-877-221-2226
Urgent Care (Contact Community First Health Plans) After Hours Connected to Nurse Advice Line	(210) 227-2347
Case Management	(210) 358-6100
Member Services Eligibility/Benefits Verification Interpreter Services - Sign and language	(210) 358-6300
TDD (for the hearing impaired)	(210) 358-6080
Outside Bexar County TTY (toll-free	1-800-390-1175
Network Management	(210) 358-6200
Claims Department (General Inquiries)	(210) 358-6200
Nurse Advise Line-After Hours	(210) 358-6000
Preventive Health & Disease Management	(210) 358-6153
Community Outreach Agencies	(210) 358-6153
Pharmacy	1-877- 908-6023

Dental InquiriesDentaQuest 1-800-508-6775
MCNA Dental free 1-800-494-6262

C. Role of the Primary Care Physician (CHIP)

The PCP plays an integral role in helping us meet the objectives of our health plan. Community First Health Plans 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 Members' 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 Member's family how to use available health services appropriately.

Primary Care Providers for CHIP Members and CHIP Perinate Newborn Members

References to "you," "my," or "I" apply if you are a CHIP member.
References to "my child" apply if your child is a CHIP member or a CHIP Perinate Newborn Member.

What is a Primary Care Provider?

The Primary Care Provider is your/your child's own doctor or clinic. The Primary Care Provider will take care of your/your child's medical needs. If a specialist or tests are needed, the Primary Care Provider will ask for them. Your/your child's Primary Care Provider must be available, in person or by phone, 24 hours a day, seven days a week. Or they must have another doctor on call. If you/your child has a serious medical condition, you may ask for a specialist to be the Primary Care Provider. This has to be approved by CFHP. The specialist also must be willing to be your/your child's Primary Care Provider Provider. It is the responsibility of the PCP to contact Community First Health Plans to verify CHIP Member eligibility and/or obtain authorizations for covered services.

The PCP, along with the Community First Health Plans' 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.

D. Role of the Primary Care Provider (CHIP Perinate Newborn)

What is a Primary Care Provider?

The Primary Care Provider is your/your child's own doctor or clinic. The Primary Care Provider will take care of your/your child's medical needs. If a specialist or tests are needed, the Primary Care Provider will ask for them. Your/your child's Primary Care Provider must be available, in person or by phone, 24 hours a day, seven days a week. Or they must have another doctor on call. If you/your child has a serious medical condition, you may ask for a specialist to be the Primary Care Provider. This has to be approved by CFHP. The specialist also must be willing to be your/your child's Primary Care Provider Provider. It is the responsibility of the PCP to contact Community First Health Plans to verify CHIP Member eligibility and/or obtain authorizations for covered Services. The PCP is responsible for teaching members 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 Perinate Members, initiate referrals to network specialty care providers, network facilities and contractors, monitor the CHIP Perinate Member's progress, facilitate the CHIP Perinate Member's return to the PCP when medically appropriate, and educate CHIP Perinate Members and their families regarding their medical care needs. It is the responsibility of the PCP to contact Community First Health Plans to verify CHIP Perinate Member eligibility and/or obtain authorizations for covered services.

The PCP along with the Community First Health Plans' case manager must coordinate with local ECI programs 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 Perinate Member's medical record. A referral for ECI services is not required; however, an Authorization for ECI Services is required.

E. Role of the Specialty Care Provider (CHIP)

The specialty care provider is responsible for providing medically necessary services to Community First Health Plans' 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 Health Plans' 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.

F. Role of the Specialty Care Provider (CHIP Perinate Newborn)

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

G. Role of Specialty Care Provider (CHIP Perinatal)

The CHIP Perinatal Provider will provide prenatal care to a pregnant woman during gestation or at delivery to provide the woman with information on immunization, newborn screening, postpartum depression and shaken baby syndrome. The Perinatal Provider will conduct nutritional risk assessment and make referrals when needed; schedule participants for nutritional counseling as needed; and provide nutritional counseling.

H. Role of Pharmacy

Community First Health Plans covers prescription medications. CHIP/CHIP-Perinatal Members can get their prescriptions for the copay when:

- They get their prescriptions filled at a network pharmacy
- Their prescriptions are on the preferred drug list (PDL) or formulary

It is important that you as the Provider know about other prescriptions your patient is already taking. Also, ask them about non-prescription medicine or vitamin or herbal supplements they may be taking.

Preferred Drug List

You can find out if a medication is on the preferred drug list. Many preferred drugs are available without prior authorization (PA). Check the list of covered drugs at:

- Texas Drug non-PA PDL Search
- PDL/PA Status Search

The Texas Medicaid preferred drug list is now available on the Epocrates drug information system, (https://online.epocrates.com/home). The service is free and provides instant access to information on the drugs covered by the Texas formulary on a Palm or Pocket PC handheld device.

Formulary Drug List

The Texas Drug Code Formulary (link to http://www.txvendordrug.com/formulary/formulary-information.shtml) covers more than 32,000 line items of drugs including single source and multi-source (generic) products. You can check to see if a medication is on the state's formulary list. Remember before prescribing these medications to your patient that it may require prior authorization.

If you want to request a drug to be added to the formulary please contact HHSC at contact@hhsc.state.tx.us

Over The Counter Drugs

Community First Health Plans also covers certain over-the-counter drugs if they are on the list. Like other drugs, over-the-counter drugs must have a prescription written by the member's physician. Check the list of covered drugs (http://www.txvendordrug.com/pdl)

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Mail Order Form for Your Members

You can assist your member in completing this form if you are prescribing a maintenance medication.

Prescription drugs must be ordered by a licensed prescriber within the scope of the prescriber's practice. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. For the most current and up-to-date version of the PDL, go to our website at www.cfhp.com.

General Guidelines

The Preferred Drug List gives you information about the drugs covered by Community First Health Plans.

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

Brand Medications

Brand medications listed on the PDL are designated in all CAPS and are covered by the plan. The PDL may cover the brand and the generic of certain medications (I.e., Depakote ER), where both the brand and generic forms of the medication are available.

Pharmacy Prior Authorization (PA)

Pharmacy prior authorization will be required if:

- The charge for any single prescription exceeds $9.99
- The prescription requires compounding
- Injectables are prescribed (those to be dispensed by a pharmacy), with the exception of heparin and insulin
- Prescriptions exceed recommended doses
- Highly specialized drugs are prescribed which require certain established clinical guidelines be met before consideration for prior approval

Procedure for Obtaining Pharmacy Prior Authorization

Navitus processes Texas Medicaid pharmacy prior authorization for Community First Health Plans Health Plans.

The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and the specific prior authorization criteria can be found at the Vendor Drug website, ePocrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online via www.navitus.com under the "Providers" section or have them faxed by Customer Care to the Prescriber' s office. Prescribers will need their NPI and State to access the portal. Completed forms can be faxed 24/7 to *Navitus* at (920) 735-5312. Prescribers can also call *Navitus* Customer Care at 1-877-908-6023 prescriber option and speak with the Prior Authorization department between 8:00 a.m. and 5:00 pm Monday through Friday Central Time to submit a PA request over the phone. After hours, Providers will have the option to leave a voicemail. Decisions regarding prior authorizations will be made within 24 hours from the time *Navitus* receives the PA request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to *Navitus*. Navitus will reimburse electronic pharmacy claims within 18 days of clean claim submission. Medications that require prior authorization will undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispending process. If the automated review

determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

When a Prior Authorization is required and the provider is not available to submit the PA request, HHSC requires pharmacies to dispense a 72 hour supply as long as the member will not be harmed if the PA is denied and therapy will be discontinued. The 72 hour emergency fill is for any Medicaid STAR or CHIP/CHIP Perinate recipient if the prescribing Provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72 hour prescription. This also applies if a PA request was submitted but *Navitus* could not make a decision within 24 hours of receipt. This procedure should not be used for routine and continuous overrides but can be used more than once if the Provider remains unavailable. If a pharmacy is not complying with the 72 hour emergency fill requirement, they can be reported to the HHSC Office of the Inspector General and *Navitus'* Network's department at (608) 729-1577 for review.

Pharmacy prior authorization requests should be faxed to (210) 358-6381. Please use the **Authorization Requirements for STAR/CHIP/HMO (Exhibit 1)**. Incomplete forms will delay processing of your request. Please also include any supporting medical records that will assist with the review of the prior authorization request. Allow 24 hours to complete a request. If the patient presents a prescription for a non-PDL drug to the pharmacy, the patient's pharmacies can contact the prescribing physician to seek consideration of a PDL alternative. In certain circumstances, upon demonstration of medical necessity, enrollees may obtain approval to receive medication not on the PDL through the pharmacy prior authorization process.

Pharmacy Vendor Customer Care: (866) 333-2757

I. Role of Main Dental Home

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

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

How to Help a Member Find Dental Care

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

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at 1-800-- 964-2777 (Medicaid Members) and 1-877-543-7669 (CHIP Members).

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

On an individual case basis, Community First Health Plans 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/Transition of Care (Exhibit 2)** and submit the form to Community First Health Plans' Health Services Management Department for review and approval by Community First Health Plans' Medical Director. To obtain further assistance in this process, please contact the Health Services Management Department at (**210) 358-6050**.

Community First Health Plans 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.

K. Provider Network Limitations

A CHIP/CHIP-PERINATAL 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/CHIP-PERINATAL 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/CHIP-PERINATAL Member may not be allowed to receive services from any physician or health care provider or hospital 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").

L. 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/CHIP-PERINATAL enrollment process.

4. Health care providers may undertake a variety of activities designed to encourage families to apply for CHIP/CHIP-PERINATAL. 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. Informing their patients of the toll-free CHIP/CHIP-PERINATAL hotline

5. Providers may educate their patients about the 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/CHIP-PERINATAL 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/CHIP-PERINATAL COVERED SERVICES (NON-CAPITATED SERVICES)

A. Coordination with Public Health Services

Community First Health Plans is required through its contractual relationship with Texas Agency Administered Programs and Essential Public Health Services regarding the provision of services for essential public health services for CHIP/CHIP-PERINATAL Members to include:

1. Early Childhood Intervention (ECI)

2. Case Management for Children and Pregnant Women (CPW)

3. Children with Special Health Care Needs (CSHCN) Program

4. School Health and Related Services (SHARS)

5. Pharmacy Benefit through *Navitus*

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)

11. Medical Transportation Program

Providers must also help Community First Health Plans in these efforts by:

1. Complying with public health reporting requirements regarding

communicable diseases and/or disease which are preventable by immunizations as defined by state law.

2. Assisting in notifying or referring to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving members.

3. Referring to the local Public Health Entity for tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons whom the member has come into contact.

4. Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons whom the member has come into contact.

5. Referring for Women, Infant and Children (WIC) services and information sharing.

6. Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.

7. Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data.

8. Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment.

9. Referring lead screening tests to the DSHS Laboratory.

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: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS — designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-	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

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	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 ▪ Inpatient services associated with: (a) Miscarriage or (b) A non-viable pregnancy (molar pregnancy ectopic pregnancy, or a fetus that expired in utero). Impatient services associated with miscarriage or non-viable pregnancy include, but are not limited: • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds; and • Histological examination of tissue samples ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies required surgical intervention and delivered as part of a proposed and clearly outlined treatment		

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	plan to treat: Cleft lip and/or palate or • Severe traumatic, skeletal and/or congenital craniofacial deviations or • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment		
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Services	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: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants Implantable devices are covered under Inpatient and Outpatient services and do not count	• May require prior authorization and Physician prescription.	Applicable level of co-pay applies to prescription drug services. Co-pays do not apply to preventive services.

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	towards the DME 12-month period Outpatient services associated with: (a) Miscarriage or (b) a non-viable pregnancy (molar pregnancy ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited: • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; Ultrasounds; and • Histological examination of tissue samples Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention including and delivered as part of a proposed and clearly outlined treatment plan to treat: • Cleft lip and/or palate or • severe traumatic, skeletal and/or congenital craniofacial deviations; or • severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: • all stages of reconstruction on the affected breast; • surgeryand reconstruction on the other breast to produce symmetrical appearance; and • treatment of physical complication from the mastectomy and treatment		

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	of lymphedemas		
Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to, vision and hearing screening and immunizations). ▪ Physician office visits, in-patient and 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 (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ 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	May require prior authorization for specialty services.	Schedule A: $3 copayment for office visits. Schedule B: $5 copayment for office visits. Schedule C: $12 copayments for office visits. Schedule D: $16 copayment for office visits. Copayments do not apply to preventive visits; or to prenatal visits after the first visit.

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. Physician and professional services for mastectomy and breast reconstruction include: • all stages of reconstruction on the affected breast; • surgery and reconstruction on the other breast to produce symmetrical appearance; and • treatment of physical complication from the mastectomy and treatment of lymphedemas Physician services associated with: (a) Miscarriage or (b) a non-viable pregnancy (molar pregnancy ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited: • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds; and • histological examination of tissue samples Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention including and delivered as part of a proposed and clearly outlined treatment plan to treat: • cleft lip and/or palate or • severe traumatic, skeletal and/or congenital craniofacial deviations; or • severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its		

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	treatment		
Home and Community Health Services	Services provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.,) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide (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 occupational therapies. ▪ 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	• Requires prior authorization • and Physician prescription • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24- hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Schedule A: None Schedule B: None Schedule C: None Schedule D: None
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	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: ▪ Orthotic braces and orthotics ▪ Prosthetic devices such as artificial eyes, limbs, and braces ▪ Prosthetic eyeglasses and contact lenses for the management of severe	• May require prior authorization and Physician prescription $20,000 12 month period limit forDME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).	Schedule A: None Schedule B: None Schedule C: None Schedule D: None

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	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. Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements (See Attachment A) ▪ Dental Devices ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit		
Case Management Services for Children with Complex Special Health Care Needs (CCSHCN)	**Case Management Services for Children with Special Health Care Needs (CSHCN)** Covered Services are above and beyond those normally provided to all Members and include, but are not limited to: • Outreach and informing—Includes discussion of Covered Services (including specialty services) with the family, the possibility of the family's right to select an 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	Available to families of children with special health care needs wanting these services.	Schedule A: None Schedule B: None Schedule C: None Schedule D: None

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	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. 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.		
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and ▪ rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapyDevelopmental assessment	Requires prior authorization and Physician prescription.	Schedule A: None Schedule B: None Schedule C: None Schedule D: None
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:: ▪ Emergency services based on prudent layperson definition of emergency health condition ▪ Hospital emergency department room and ancillary services and Physician services 24 hours a day, 7 days a week, both by in-network and out-of-network 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	Requires 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

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	services ▪ Emergency ground, air and water transportation ▪ Emergency dental services (e.g., anesthesia and drugs) for: ▪ Treatment of a fractured or dislocated jaw. Traumatic damage to teeth, and removal of cysts ▪ Oral abscess of tooth or gum origin ▪ Treatment and devices for craniofacial anomalies		
Transplants	Covered 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: • 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.
Hospice Care Services	Medically necessary hospice services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment for unrelated conditions is unaffected	Requires prior authorization for post-stabilization services. Requires authorization and physician prescription Services apply to the hospice diagnosis Up to a maximum of 120 days with a 6 month life expectancy Patient electing hospice waive their rights to treatment related to their terminal illnesses; however they may cancel this election at any time	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	Applicable level of co-pay applies to office visits billed for refractive exam,

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
		additional visits.	
Tobacco Cessation Programs	Covered up to $100 for a 12-month period limit for a plan-approved program	Does not require . Health Plan defines plan-approved program. May be subject to formulary requirements	Co-pays do not apply,
Vision Benefit	Medically necessary services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period • Additional eye health care services provided by an in-network Optometrist or Ophthalmologist (other than surgery) can be provided without a referral from the member's Primary Care Provider. Covered surgical/laser care requires prior authorization	The health plan may reasonably limit the cost of the frames/lenses. • Does not require. 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 Health Plans' responsibilities shown above are subject to contractual requirements between Community First Health Plans and Provider (i.e., Authorization List, Claim Submission Requirements) and Member eligibility for CHIP.

1. Emergency Dental Services:

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

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

2. Non-Emergency Dental Services

Community First Health Plans is **not responsible** for paying for routine dental services provider to CHIP/CHIP Perinate members. These services are paid through Dental Managed Care Organizations.

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

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 Health Plans

- 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 Health Plans 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 Health Plans

- 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.
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		
Dental Devices	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	

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.
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	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: • 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 Does not include formula: • 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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			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. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parentally.
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,

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			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 Health Plans has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: 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 catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

IV. CHIP-PERINATAL COVERED BENEFITS

A. CHIP Perinate Newborn and CHIP Perinatal Schedule of Benefits

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	▪ For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit for the initial Perinate Newborn admission; however, facility charges are a covered benefit after the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth. ▪ For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, professional service charges are a covered benefit for the initial Perinate Newborn admission and subsequent admissions. "Initial Perinate Newborn admission" means the hospitalization associated with the birth. Services include, but are not limited to, the following: ▪ Requires authorization for non-emergency care and care following stabilization of an emergency condition. ▪ 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	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes between 186% and 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery. Covered medically necessary Hospital-provided services are limited to labor with delivery until birth. Services include: ▪ Requires authorization for in-network or out-of-network facility and physician services for mother and newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 following uncomplicated delivery by caesarian section. ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) Surgical dressings, trays, casts, splints ▪ Drugs, medications and biological ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ 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	▪ Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child.
Skilled Nursing Facilities	Services include, but are not limited to, the following:	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
(Includes Rehabilitation Hospitals)	▪ Requires authorization and physician prescription ▪ 60 days per 12 month period limit. ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ May require authorization and physician prescription. ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory	Services include, 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: ▪ May require prior authorization and physician prescription. ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs. (1)Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2)Ultrasound of the pregnant uterus is a covered benefit when medically indicated.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	surgical facility. ▪ 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.	Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. (3)Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4)Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) Physician office visits, inpatient 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 (in/outpatient) of surgical services, including: ▪ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ▪ Administration of anesthesia by Physician (other than surgeon) or CRNA ▪ Second surgical opinions ▪ Same-day surgery performed in a Hospital without an over-night stay ▪ Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician performed technical and interpretive components) ▪ In-network and out-of-network	Services include, but are not limited to the following: ▪ May require authorization for specialty services ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth ▪ Physician office visits, inpatient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: ▪ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. ▪ Administration of anesthesia by Physician (other than surgeon) or CRNA ▪ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	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 ▪ May require authorization for specialty services.	▪ Hospital-based Physician services (including Physician performed technical and interpretive components) ▪ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. ▪ Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Not a covered benefit.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: ▪ Does not require prior authorization. (1)One visit every four weeks for the first 28 weeks of pregnancy; (2)One visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3)One visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	May require authorization and physician prescription. $20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	supplies and equipment are not counted against this cap). 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: ▪ 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 ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: ▪ Require prior authorization and physician prescription. ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	approved. ▪ Speech, physical and occupational therapies. ▪ 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	
Inpatient Mental Health Services .	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Require prior authorization for non emergency services. ▪ 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 matter for determination ▪ 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost ▪ 20 of the inpatient days must be held in reserve for inpatient use only ▪ Does not require PCP referral	
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ May require prior authorization. ▪ 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 the basis of financial equivalence against the outpatient visit cost ▪ Includes outpatient psychiatric services, up to 12-month period limit, ordered by a court of	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	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 ▪ A Qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a 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 Substance Abuse Treatment Services .	Services include, but are not limited to: ▪ Require prior authorization for non-emergency service.	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs ▪ 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. ▪ 30 days must be held in reserve for inpatient use only.	
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: ▪ May require prior authorization ▪ 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 nonresidential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 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	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	a maximum of: ▪ Intensive outpatient program (up to 12 weeks per 12-month period) ▪ Outpatient services (up to six months per 12-month period) ▪ Does not require PCP referral	
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Requires prior authorization and physician prescription. ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: ▪ Requires prior authorization and physician prescription. ▪ 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 ▪ Up to a maximum of 120 days with a 6 month life expectancy ▪ Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime ▪ Services apply to the hospice diagnosis	None
Emergency Services, including Emergency Hospitals, Physicians, and	HMO cannot require authorization as a condition for payment for emergency conditions labor and	HMO cannot require authorization as a condition for payment for emergency

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Ambulance Services	delivery. Covered services include, but are not limited to, the following: ▪ Requires authorization for post stabilization services ▪ ▪ Emergency services based on prudent layperson definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level I 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. Treatment of oral abscess of tooth or gum origin and treatment and devices for craniofacial anomalies	conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. ▪ Emergency services based on prudent layperson definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor with delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to the following: ▪ Requires Authorization ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: ▪ Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered disease of eye. ▪ 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	Not a covered benefit.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation. ▪ Does not require authorization for 12 visit per 12 months period limit (regardless of number of services or modalities provided in one visit). ▪ Require authorization for additional visits	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program. ▪ Does not require authorization ▪ Health Plan defines plan approved program. ▪ May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	▪ These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Value-added services	Free Flu Shots Discount Pharmacy Benefit	Free Flu Shots Discount Pharmacy Benefit

B. CHIP Perinate Newborn and CHIP Perinatal Exclusions from Covered

Services

1. CHIP Perinatal Service Exclusions from Covered Services for CHIP Perinates

   For CHIP Perinate families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.

   Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth.

   - Inpatient mental health services.
   - Outpatient mental health services.
   - Durable medical equipment or other medically related remedial devices.
   - Disposable medical supplies.
   - Home and community-based health care services.
   - Nursing care services.
   - Dental services.
   - Inpatient substance abuse treatment services and residential substance abuse treatment services.
   - Outpatient substance abuse treatment services.
   - Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
   - Hospice care.
   - Skilled nursing facility and rehabilitation hospital services.
   - Emergency services other than those directly related to the labor with delivery of the covered unborn child.
   - Transplant services.
   - Tobacco Cessation Programs.

- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post-partum care.
- 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
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- 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 Health Plans except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity

- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (Care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

2. Exclusions from Covered Services for CHIP Perinate Newborns

With the exception of the first bullet, all of the following exclusions match those found in the CHIP Program.

- For CHIP Perinatal Newborns in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system

- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles 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

- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.

- Mechanical organ replacement devices including, but not limited to artificial heart

- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Community First Health Plans

- Prostate and mammography screening

- Elective surgery to correct vision

- Gastric procedures for weight loss

- Cosmetic surgery/services solely for cosmetic purposes

- Out-of-network services not authorized by the Community First Health Plans 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 the Community First Health Plans
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice 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

- Charges incurred as a donor of an organ when the recipient is not covered under this Community First Health Plans

3. CHIP & CHIP Perinatal Program DME/Supplies

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns.

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.
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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			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.
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	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: • 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 Does not include formula: • 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,

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			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. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			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 Health Plans has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: 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 catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

V. BEHAVIORAL HEALTH CHIP/CHIP-PERINATE

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.

CHIP/CHIP-PERINATE inpatient and outpatient behavioral health services for 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 Request for Authorized Services (Exhibit 3)**. If the member needs additional psychological testing, provider must submit **Psychological Testing Request Form (Exhibit 4)** to the Health Plan. For eligibility and benefit information/limitations, contact Community First Health Plans Member Service Department (210) 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 Intelligence Scale-Revised (WAIS-R), Rorschach, and 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	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • 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		Schedule A: $3 copayment for office visits. Schedule B: $5 copayment for office visits. Schedule C: $12 copayments for office visits. Schedule D: $16 copayment for office visits.

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	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 • 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 • Neuropsychological and Psychological testing • Does not require PCP referral		
Inpatient Mental Health Services	Mental Health services, including for serious mental illness, furnished in a free standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • 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	Requires prior authorization for non-emergency services, does not require PCP referral.	Schedule A: $10 inpatient copayment Schedule B: $25 inpatient copayment Schedule C: $50 inpatient copayment Schedule D: $100 inpatient copayment

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
	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 • 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 cost • 20 of the inpatient days must be held in reserve for inpatient use only. Does not require PCP referral.		
Outpatient Substance Abuse Treatment Services	• 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 Outpatient services (up to six months per 12-month period)	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.

TYPE OF BENEFIT	DESCRIPTION OF BENEFIT	LIMITATIONS AND/OR EXCLUSIONS	CO-PAY AND/OR DEDUCTIBLE
Inpatient Substance Abuse Treatment Service	Services include, but are not limited to : • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • 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. 30 days must be held in reserve for inpatient use only.	Require prior authorization for non-emergency services, does not require PCP referral.	Schedule A: $10 inpatient copayment Schedule B: $25 inpatient copayment Schedule C: $50 inpatient copayment Schedule D: $100 inpatient copayment

B. PCP Requirements for Behavioral Health

1. Community First Health Plans' PCPs 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 Health Plans' PCPs 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 Health Plans' CHIP/CHIP-PERINATE members through the following:

   a. Self-referral to any Community First Health Plans participating Behavioral Health Provider.

   b. Community First Health Plans 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 Health Plans' PCPs 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 (DSM-IV).

   c. Maintenance of consents for disclosure of information. Behavioral Health providers are required to send initial and quarterly summary reports to PCP. Please see Behavioral Health Report to **Primary Care Physician (Exhibit 5)**.

   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 Quality Management and Improvement Program (QMIP) to objectively and systematically monitor and evaluate the quality of care and service provided to Community First Health Plans' CHIP/CHIP-PERINATE 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 Health Plans' Provider newsletter.

   b. 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.

   c. Community First Health Plans requires that all Behavioral Health Providers contact Members, who have missed appointments within 24 hours to reschedule appointment.

VI. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

A. Introduction

Our 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/CHIP-PERINATAL/CHIP-PERINATE 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/CHIP-PERINATAL Members upon request;

2. Maintaining the confidentiality of CHIP/CHIP-PERINATAL 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 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.

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 contract or 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.

Provider must provide access wherever Provider maintains such records, books, documents, and papers. 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 Health Plans 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 Health Plans' 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 Health Plans are presented to the Credentials Committee for final approval of their credentials and participation with Community First Health Plans. All Mid-levels are required to submit a Supervising Physician form. **(Exhibit 24)**

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/CHIP-PERINATE Member survey results;

2. Complaints and Grievances;

3. Utilization data;

4. Compliance with Community First Health Plans policies and procedures;

5. An office site review and evaluation, and;

6. A medical record audit.

VII. PROVIDER RESPONSIBILITIES

A. PCP (Medical Home) Responsibilities

1. PCP Availability and Accessibility Standards

   Network PCPs must be accessible to CHIP/CHIP-PERINATE 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/CHIP-PERINATE Member prior to rendering services by calling Community First Health Plans 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 Health Plans' Members. Because Community First Health Plans 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 Health Plans can identify opportunities to improve our

performance, and to develop and implement intervention strategies to effect any necessary improvement.

Community First Health Plans has Primary Care Physicians (PCPs) 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 Health Plans' 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.

It is the responsibility of the Provider to communicate to Community First Health Plans a new office location, a new change of address and/or telephone number immediately.

TYPE OF APPOINTMENT	APPOINTMENT AVAILABILITY
Emergency Care, including Behavioral Health	24 hours a day, 7 days a week, upon Member presentation at the delivery 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/scheduled inpatient/outpatient care	Within 14 days of request Within 14 days of request Within 14 days of request
Behavioral Health Discharge Planning/Aftercare	Members discharged from an impatient 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).
Prenatal Care (Initial)	14 calendar days or less or by the 12th week of gestation. Members who 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 exists.
Texas Health Steps Medical Checkups	Within 14 days of enrollment and no later

TYPE OF APPOINTMENT	APPOINTMENT AVAILABILITY
	than 60 days of enrollment for other eligible child members and in accordance with HHSC published periodocoty schedule of Texas Health Steps.
Well-Child Care	Routine Well-Child Care: In accordance with Academy of Pediatrics periodicity schedule
Well adolescent care	Routine Well Adolescent Care: In accordance with American Academy of Pediatrics periodicity schedule and CFHP's Quality Improvement Guidelines, as amended from time to time.
Migrant Farm Worker Children	Staff must ensure prompt delivery of services to children of migrant farm workers and other migrant populations who may transition into or out of HMO program more rapidly and/or unpredictably than the general population.
Newborn Care (in a hospital)	Newborns must receive an initial newborn checkup before discharge from the hospital to include all required tests and immunizations.
Newborn Care (after discharge from a hospital)	Within 3 to 5 days after birth and then within 14 days of hospital discharge.
Preventive 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 Service 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

TYPE OF APPOINTMENT	APPOINTMENT AVAILABILITY
	physician within 4 hours of detection.
Provider office waiting time	Within 30 minutes of scheduled appointment time.
Requests for feedback from pharmacy related to prescriptions	Within 24 business hours.

C. Children of Migrant Farmworkers

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

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

D. Plan Termination

1. Provider Request for Termination

The Provider may terminate the Agreement with Community First Health Plans, 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 Health Plans 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 Health Plans.

2. Health Plan Request for Termination

Community First Health Plans 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 Health Plans must provide a written explanation to the Provider of the reasons for termination. Community First Health Plans 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 Health Plans 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

E. Members Right to Designate any OB/GYN

Community First Health Plans allows you to pick any OB/GYN whether that doctor is within the same network as your Primary Care Provider or not.

A Member has the right to select any OB/GYN without a referral from their PCP. Any OB/GYN can give you:

1. One well-woman check-up each year
2. Care related to pregnancy
3. Care for any female medical condition
4. A referral to specialist doctor within the network

F. Referral to Specialists and Health Related Services

1. The **Texas Referral/Authorization Form (Exhibit 6)** 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 its practice.
3. Community First Health Plans will authorize referrals to participating Facilities and participating Providers.
4. Community First Health Plans will work with participating Providers for CHIP/CHIP-PERINATAL Members who request a second opinion.

G. Specialty Provider Responsibilities

The Specialty Care Provider is responsible for providing medically necessary services to Community First Health Plans' CHIP/CHIP-PERINATE Members who have been referred by their PCP for specified treatment or diagnoses. Specialists should always verify the eligibility of the referred CHIP/CHIP-PERINATE Member prior to rendering services. Specialists requesting services that require authorization must request the

authorization from Community First Health Plans' 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 Specialist 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 Specialist or another Provider designated by the Specialist. 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 Specialist 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.

H. Verifying Member Eligibility and Benefits

Specialists should always verify the eligibility of the referred CHIP/CHIP-PERINATAL/CHIP-PERINATE Member prior to rendering services by calling Community First Health Plans' Member Services Department at (210) 358-6300 during office hours.

I. CFHP Member Id Cards

You will get a CFHP ID card for each person enrolled in the plan. If you do not get a card, call Member Services. We will send you a card. You

card will list:

a. Your name or your child's name
b. Member Id number
c. Your effective date
d. Your Primary Care Providers name, address, and phone number
e. Your copayments (for CHIP members only. CHIP Perinatal members do not have a copayment)
f. What to do in an emergency
g. How to reach Member Services
h. How to get help in Spanish

Carry this card with you at all times. Show the ID card to your doctor so they know you are covered by the CFHP program. **Exhibit 24**

J. 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 7)** from such a Member.

K. Member's Continuity of Care

Community First Health Plans provides CHIP/CHIP-PERINATAL/CHIP-PERINATE 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
3. Pregnant woman information
4. Pre-existing condition not imposed

L. Changing Health Plans

CHIP Members

What if I want to change health plans?

You are allowed to make health plan changes:

1. for any reason within 90 days of enrollment in CHIP and once thereafter;

2. for causes at any time;
3. if you move to a different service delivery area; and
4. during the annual CHIP re-enrollment period.

Who do I call?
For more information, call CHIP toll-free at 1-800-647-6558.

CHIP Perinatal Members

1. **Attention:** If you meet certain Income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.
2. Your baby will continue to receive services through the CHIP program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of . continuous CHIP Perinatal Program coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

What If I want to change health plans?

1. Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal Program coverage ends. The 12 month CHIP Perinatal coverage begins when your unborn child is enrolled in

CHIP Perinatal Program and continues after your child is born.

2. If you live in an area with more than one CHIP Perinatal Program health plan, and you do ***not*** pick a plan within 15 days of getting the enrollment packet, HHSC will pick a health plan for your unborn child and send you information about that health plan. If HHSC picks a health plan for your unborn child, you will have 90 days to pick another health plan if you are not happy with the plan HHSC choses.
3. If you have children covered by CHIP, their health plans might change once you are approved for CHIP Perinatal coverage. When a member of the family is approved for CHIP Perinatal coverage and picks a perinatal health plan, all children in the family that are enrolled in CHIP must join the health plan providing the CHIP Perinatal services. The children must remain with the same health plan until the end of the CHIP Perinatal member's enrollment period, or the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for the children.
4. You can ask to change health plans:

- for any reason within 90 days of enrollment in CHIP Perinatal;
- if you move to a different service delivery area; and
- for cause at any time.

Who do I call?

For more information, call toll-free at 1-800-647-6558.

How many times can I change health plans?

You are allowed to make health plan changes for any reason within 90 days of enrollment in CHIP, for cause at any time, or during the annual re-enrollment period.

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can CFHP ask that I get dropped from their health plan (for non-compliance, etc.)?

We can ask to drop you if you do any of these things:

- Move out of our service area.
- You are not able to get Medicaid.
- Enter a hospice or long-term care facility.
- You do not follow CFHP policies and procedures.
- Let someone else use your CFHP Member ID card.
- You are rude, abusive or you do not work with CFHP staff, primary care
- providers, other providers, or their staff.

Concurrent Enrollment of Family Members in the CHIP and CHIP Perinatal Programs, and Medicaid Coverage for Certain Newborns

If you are a CHIP Perinatal member and have children covered by CHIP, they will continue to receive CHIP benefits, but will be moved to the same health plan that is providing the CHIP Perinatal coverage. Co-payments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP Program.

Families at or below 185% of the Federal Poverty Level:

If you are pregnant and in the CHIP Perinatal Program, your baby will be moved to Medicaid for 12 months of continuous Medicaid coverage when he or she is born.

Families above 185% to 200% of the Federal Poverty Level:

If you are pregnant and in the CHIP Perinatal Program, your baby will continue to get coverage through the CHIP Program as a "CHIP Perinatal Newborn" when he or she is born.

M. Transition of Care

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.

N. 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 (HIPAA) 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 – relevant past medical history for each encounter.

O. 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.

a. The Provider must have specific recollection of the services provided which is documented.

b. A Provider may add a missing signature without a time restriction if the provider created the original documentation him/herself.

c. 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.

d. 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 rational 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.

P. Access to Medical Records

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

1. all information required under the Community First Health Plans' 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.

Q. 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

R. 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.

S. Justification to Community First Health Plans regarding Out of Network Referrals Including Providers Not Contracted with Community First Health Plans.

When Community First Health Plans 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/CHIP-PERINATAL/CHIP-PERINATE Member.

T. Advance Directives

a. Physicians

Federal law requires HMOs and Providers to maintain written policies and procedures for informing and providing written information to all Members and Member Guardians about their rights and under State and Federal law, in advance of their receiving care)Social Security Act Section 1902(a)(57) and Section 1903 (m)(1)(A). These must contain procedures for providing written information regarding the Member's rights to refuse, withhold or withdraw medical treatment in advance.

Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE policies and procedures must meet the program rules with provisions contained in 42 CFR Section 434.28 and 42 CFR Section 489, Sub Part I, about advance directives for all hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices, as well as state laws and rules.

Community First Health Plans CHIP/CHIP-PERINATAL/CHIP-PERINATE will help the Provider in understanding the requirements for advance directives and how to follow the laws and rules written for such a purpose. Community First Health Plans' advance directives include:

- The emancipated Member's or Guardian's right under the Natural Death Act (Texas Health and Safety Code Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;
- The emancipated Member's or Guardian's rights to self-determination in making health care decisions;
- The emancipated Member's or Guardian's right under Texas Health and Safety Code, Chapter 674, about written and non-written Out-Of-Hospital Do-Not-Resuscitate Orders;

- The emancipated Member's or Guardian's right to execute a Durable Power of Attorney for Health Care regarding their right to appoint an agent to make medical treatment decisions on their behalf if the Member becomes incapacitated (Civil Practice and Remedies Code, Chapter 135); and
- Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE policies for implementing a Member's advance directives, including a clear and concise statement of limitations if Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE or a participating Provider cannot or will not be able to carry out a Member's advance directive.

  A statement of limitation on implementing a Member's advance directive should include at least the following information:

  Clarify any differences between Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE conscience objection and those which can be raised by the Member's Primary Care Provider or other Providers;
- Identify the state legal authority permitting Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE conscience objections to carrying out an advance directive;
- Describe the range of medical conditions or procedures affected by the conscience objection.

b. Members

Members have the right to pick the medical care they want or do not want. Emancipated Members or Guardians can ask for doctors, nurses, and other people to handle their care, what type of care they want and the kind they don't want. In some cases members can choose to:

- Accept care
- Reject care
- Stop care

There can be circumstances in which emancipated patients can ask for a doctor to perform or react in advance of a procedure. Patients often become too ill to talk, or slip into a coma. Advance Directives aid providers in carrying out incapacitated patient wishes. An Advance Directive protects patient wishes when they can't speak on their own behalf.

There are two types of Advance Directives:

- Advance Directive:
  This is a record of their wishes. They can either write down their wishes or inform their doctor. Should an emancipated child patient become incapacitated, an Advance Directive details the type of care they want or do not want. For example, "If I have a heart attack, I do not wish to be revived."

- Appointed Health Care Representative:
  An emancipated child Member can pick someone to make decisions about their health care needs if they are not able to. They must put this choice into a legal document (letter). The person chosen can be a friend, family member or lawyer.

Members can choose both to inform a doctor ahead of time and to pick a person to make choices if they cannot do so for themselves. If you have any questions about member rights or how to put them down on paper, call us toll free at 1-800-434-2347.

VIII. ROUTINE, URGENT, AND EMERGENCY SERVICES

A. Routine Care

Routine/Non-Emergent Condition is a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

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/CHIP-PERINATE Member's PCP or PCP designee to prevent serious deterioration of the CHIP/CHIP-PERINATE Member's condition or health.

CHIP-PERINATAL Members should seek care from their assigned OB-GYN.

For after hour's urgent care, and certain instances during normal office hours, Community First Health Plans 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/CHIP-PERINATE Members in accessing treatment.
Services provided at the Urgent Care Clinics are limited to:

1. After Hours Urgent Care

Weekdays/Weekends	Monday-Friday	5:00 p.m. – 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.

3. Requirements for Scheduling Appointments

Referrals to the Urgent Care Clinic: When referring a 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 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 Plans' Health Services Management Department, or the Nurse Advice Line.

If the examining physician determines that a ***true medical emergency exists***, the CHIP/CHIP Perinate 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 Health Plans' network hospital.

C. **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/CHIP-PERINATAL/CHIP-PERINATE Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in:

1. Placing the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member's health in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction to any bodily organ or part;

4. Serious disfigurement;

5. In the case of a pregnant woman, serious jeopardy to the health of the fetus; or

6. The facility staff will work with Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Medical management staff in preparation of all discharge planning and/or referral to outpatient/ancillary services including home health and DME; NOTE**:** Home Health and DME are NOT covered benefits of Community First Health Plans' CHIP-PERINATE services.

Community First Health Plans covers services for a medical emergency anywhere in the United States, 24 hours a day. If a medical emergency occurs, whether in or out of Community First Health Plans' service area, CHIP/CHIP-PERINATAL/CHIP-PERINATE Members are instructed to seek care at the nearest hospital emergency room or comparable facility. The necessary emergency care services will be provided to cover CHIP/CHIP-PERINATAL/CHIP-PERINATE 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/CHIP-PERINATAL/CHIP-PERINATE 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/CHIP-PERINATAL/CHIP-PERINATE Member needs to be transferred to another facility and the medical condition of the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member requires immediate medical attention, the transfer may be considered as an emergency transfer.

Community First Health Plans 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/CHIP-PERINATAL/CHIP-PERINATE Member must contact his or her PCP to arrange any non-emergency care needed. If the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans to obtain authorization for any necessary post-stabilization services.

Admission to Out-Of-Network Facilities

If a Community First Health Plans' CHIP/CHIP-PERINATE member is admitted to a non-participating facility, such an admission must first be approved by the member's Primary Care Provider and authorized by Community First Health Plans except in the case of an emergency. If a Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE member has been admitted to a non-participating facility on an emergency basis, the Member should be transferred to a participating facility as soon as it is medically safe to do so. The member's Primary Care Provider will coordinate or Community First Health Plans' staff will arrange the transfer.

D. Emergency and Non-Emergency Transportation

1. When an emergency situation exists, a prudent 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.

3. Medical Transportation Program – Is an alternate means of transportation available to members in non-emergency situations.

E. Emergency Prescription Supply

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

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

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

To be reimbursed for 72-hour emergency prescription supply, pharmacies should contact Navitus Health Solutions' Provider Hotline at phone number at -877- 908-6023. Contact Navitus Health Solutions' Provider Hotline at phone number (877) 908-6023, for more information about the 72-hour emergency prescription supply policy.

IX. CHIP/CHIP-PERINATAL AND APPEALS

A. Provider Complaint and Appeal Process

Community First Health Plans has a process to address Provider complaints in a timely manner, which is consistent for all network providers. Community First Health Plans 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 Health Plans, 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 Health Plans' 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 8)** with a transmittal letter. The provider must complete the form and return the form to Community First Health Plans' Network Management Department for prompt resolution of the complaint. Once the Provider Complaint Form is received by Community First Health Plans' 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, Community First Health Plans will send a letter to communicate 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 Health Plans are unable to resolve the complaint, the Provider may submit an appeal, orally or in writing, to Community First Health Plans. Upon receipt of a written appeal, Community First Health Plans 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 Health Plans' Network Management Department will send an **Appeal Submission Form (Exhibit 9)** to the Provider to complete and return to Community First Health Plans.

Community First Health Plans will send written notification within 30 calendar days from the receipt of the appeal to the Provider of the proposed resolution. This notification will constitute Community First Health Plans' 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 Health Plans 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.

X. CHIP/CHIP PERINATAL/CHIP PERINATE MEMBER COMPLAINTS AND APPEALS

A. Member Complaint Process

A complaint is an expression of dissatisfaction expressed orally or in writing to Community First Health Plans or health plan subcontractors by a Member or authorized representative, regarding any aspect of health plan operation, including but not limited to dissatisfaction with plan administration, procedures related to Appeal of an adverse determination, as defined in the Texas Insurance, Chapter 843, Subchapter G; the denial, reduction or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member. If the Member wishes to file a complaint, Community First Health Plans is here to help. Please direct them to call Member Services at (210) 358-6300 or toll-free at 1-800-434-2347.

What should I do if I have a complaint?

Members may file a complaint with Community First Health Plans at any time. We will mail a letter to the complainant within 5 days, to acknowledge receipt of verbal and written complaints. For verbal complaints, the letter will include a complaint form. The complaint form must be returned to Community First Health Plans for prompt resolution of the complaint. A letter will be mailed to the Member with our decision within 30 days after the date of receipt of a written complaint or complaint form. Members may send their written complaint or complaint form to:

Community First Health Plans Health Plans Inc.
ATTN: Member Services Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

Who do I call?

Call Community First Health Plans at 1-800-434-2347.

Can a representative from Community First Health Plans help the CHIP/CHIP-PERINATAL/CHIP-PERINATE Members file a complaint?

Yes, Members may request assistance from a Community First Health Plans' Member Services Representative.

How long will it take to investigate and solve my complaint?

Community First Health Plans will notify Member within five days of receipt of complaint. A letter will be mailed to the Member with important information regarding their complaint process. A resolution to the complaint will be provided to the Member within 30 calendar days from the date we receive the written complaint.

If I am not satisfied with the outcome, who else can I call?

If the Member is not satisfied with the outcome of the Complaint, the Member may file a complaint with the Texas Department of Insurance (TDI):

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
(800) 252-3439
Fax (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

B. Member Appeal Process

Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Members may request an appeal if Community First Health Plans denies or limits a request for a covered service. Community First Health Plans will mail the Member a complaint appeal acknowledgement letter within 5 calendar days from the date we receive a written complaint appeal or complaint appeal form. Community First Health Plans will schedule a Complaint Appeal Panel hearing.

Five days before the hearing, a letter will be mailed to the Member with important information regarding their complaint appeal rights. The Member may appear in person before the Appeal Panel, or submit written information. After the Appeal Hearing and within 30 calendar days from the date we receive the written complaint appeal, Community First Health Plans will send the Member a decision.

If the Member is not satisfied with the outcome of the Complaint Appeal Hearing, the Member may file a complaint with the Texas Department of Insurance (TDI). The member may contact TDI at:

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
(800) 252-3439
Fax (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

What can a Community First Health Plans CHIP/CHIP-PERINATAL/CHIP-PERINATE Member do if Community First Health Plans denies or limits a request for a covered service?

The Member may request an appeal orally or in writing with Community First Health Plans' Health Management Resolution Unit.

How will the Community First Health Plans CHIP/CHIP-PERINATAL/CHIP-PERINATE member be notified if services are denied?

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

What is the time frame for the appeal process?

Community First Health Plans 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 Health Plans. Oral appeals that are received by Community First Health Plans should 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 Health Plans help the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member file an appeal?

Members may request assistance from a Community First Health Plans' Member Services Representative.

C. Expedited Community First Health Plans' Member Appeal

Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Members may request an expedited appeal if the Member is not satisfied with the outcome of the complaint process.

How can a Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Member request an expedited appeal?

Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Member may request an expedited appeal orally or in writing, when Community First Health Plans 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 such as denial of emergency care, a life threatening condition or an inpatient hospitalization.

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 is made to Community First Health Plans.

What happens if Community First Health Plans 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.

Who can help me file an expedited appeal?

Members may request assistance from a Community First Health Plans' Member Services Representative.

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 Health Plans. The IRO reviews unresolved appeals, as coordinated by the Texas Department of Insurance.

How does a Community First Health Plans CHIP/CHIP-PERINATAL/CHIP-PERINATE member request an IRO?

The Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Member should submit a request for an IRO to Community First Health Plans'

Health Services Management Resolution Unit and will be forwarded to the Texas Department of Insurance for assignment:

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

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

The IRO must make their determination by the 15th day after the IRO receives the information necessary to make a determination or by the 20th day after the IRO receives the request

XI. CHIP/CHIP PERINATAL/CHIP PERINATE MEMBER ELIGIBILITY AND ADDED BENEFITS

A. Member Eligibility

Each CHIP/CHIP-PERINATAL/CHIP-PERINATE Member is issued an Identification Card and is instructed to present the Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE ID Card when requesting medical services. The CHIP/CHIP-PERINATE ID Card indicates pertinent CHIP/CHIP-PERINATE Member information, PCP name and telephone number, Co-payment amounts and Community First Health Plans' telephone numbers. CHIP-PERINATAL ID card indicates pertinent Member information, OB-GYN name and telephone number, and Community First Health Plans' telephone numbers.

At the time of the visit, ask the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member to show the Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE ID card. The Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE ID Card, however, does not guarantee eligibility for coverage.

If a CHIP/CHIP-PERINATE Member has selected a PCP who is part of a Limited Provider Network you may not see that CHIP/CHIP-PERINATE 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** or outside Bexar County at 1-**800-434-2347**

2. On-line: Community First Health Plans' Provider Web Portal

When a CHIP/CHIP-PERINATE Member has questions about benefit coverage or wants to change to another PCP, please ask the CHIP/CHIP-PERINATE Member to call our Member Services Department at (**210) 358-6300 or 1-800-434-2347.**

When a CHIP-PERINATAL Member has questions about benefit coverage or wants to change to another OB-GYN, please ask the CHIP-PERINATAL Member to call our Member Services Department at (**210) 358-6300 or 1-800-434-2347.**

B. Pregnancy and CHIP Eligibility

CHIP Members should contact Community First Health Plans' Member Services as soon as the Member is aware of the pregnancy. The pregnant Member needs to apply immediately for services through the Medicaid Program and her baby will also likely be able to receive health care coverage through the Medicaid Program. Providers are required to contact Community First Health Plans when a pregnant CHIP Member is identified.

C. Span of Eligibility

Community First Health Plans will arrange for all covered services for the period CHIP/CHIP-PERINATAL/CHIP-PERINATE Members are eligible with Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Service. Eligibility is spanned in 12 month increments. Determination of eligibility is assumed by the Administrative Services Contractor.

Covered CHIP/CHIP-PERINATE services must meet the CHIP/CHIP-PERINATE 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/CHIP-PERINATE 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 spell of illness limitation for CHIP Members and CHIP Perinate Newborn Members. There is no lifetime maximum on benefits; however, **12-month period** or lifetime limitations do apply to certain services. Deductibles and copays apply until a family reaches its specific cost-sharing maximum.

3. Value Added Benefits
GET NEW VALUE ADDED BENEFITS

CHIP/CHIP-PERINATE

- $125 allowance on prescription lenses and frames
- A prescription discount card your whole family can use
- Free sports physicals
- 24-hour nurse advice line
- Bus tokens for medical appointments and health education classes
- Weight management program for teens

- Member gift cards programs
- Free flu shots for CHIP Perinatal members
- Healthy Expectations Prenatal program
- ER Reduction kit
- Asthma kits
- Asthma pillow cover
- Smoking Cessation program
- Diabetes program incentive
- Adult lifestyle classes
- Expectant mommy baby shower
- Newborn and postpartum classes for new fathers
- New mommy mingle and advice meetings
- MP3 player with health podcast
- Temporary phone help
- Post-discharge incentives
- Free toddler booster seats
- Bike safety and repair classes
- Zumba classes
- Notary services
-

CHIP-PERINATAL

- A prescription discount card your whole family can use
- 24-hour nurse advice line
- Bus tokens for doctor visits or health classes
- Free flu shots for CHIP Perinatal members
- Healthy Expectations prenatal program
- Expectant mommy baby shower
- Newborn and postpartum classes for new fathers
- New mommy mingle and advice meetings
- MP3 player with health podcast
- Temporary phone help
- Post-discharge incentives
- Free toddler booster seats
- Notary services

* Co-payments do not apply to preventive services or pregnancy-related assistance

D. Identifying CHIP/CHIP-Perinatal/CHIP-Perinate Members

SAMPLE **CHIP/CHIP-Perinatal/CHIP-Perinate Member Identification Card (Exhibit 10)**

XII. MEMBER RIGHTS AND RESPONSIBILITIES

A. Member Rights and Responsibilities

CHIP MEMBER RIGHTS:

- Members have a right to get information about Community First, its services, its
- providers, and member rights and responsibilities.
  Members have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
- Members have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
- Members have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
- Members have a right to know the names of the hospitals and other Perinatal providers In the health plan and their addresses.
- Members have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
- Members have the right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
- Members have the right and responsibility to take part in all the choices about your unborn child's health care.
- Members have the right to speak for your unborn child in all treatment choices.
- Members have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
- Members have the right to talk to your Perinatal provider In private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
- Members have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay

for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you If they think your doctor of the health plan was right.

- Members have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- Members have a right to make recommendations regarding Community First's member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

Members and your health plan both have an interest In having your baby born healthy.

- Members can help by assuming these responsibilities.
- Members must understand your health problems and work with your provider to develop agreed-upon goals (to the degree possible).
- Members must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
- Members must become involved in the decisions about your unborn child's care.
- If members have a disagreement with the health plan, you must try first try to resolve it using the health plan's complaint process.
- Members must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
- Members must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
- Members must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
- Members must talk to your provider about your medications that are prescribed.
- Members have a responsibility to provide information to Community First or its providers (to the degree possible) that is needed to provide care.

If members think they have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

FOR CHIP PERINATE MEMBERS

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

- Members have a right to get information about Community First, its services, its providers, and member rights and responsibilities.
- Members have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
- Members have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
- Members have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
- Members have a right to know the names of the hospitals and other Perinatal providers In the health plan and their addresses.
- Members have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
- Members have the right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
- Members have the right and responsibility to take part in all the choices about your unborn child's health care.
- Members have the right to speak for your unborn child in all treatment choices.
- Members have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
- Members have the right to talk to your Perinatal provider In private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
- Members have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who

provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you If they think your doctor of the health plan was right.

- Members have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- Members have a right to make recommendations regarding Community First's member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

Members and your health plan both have an interest In having your baby born healthy. You can help by assuming these responsibilities.

1. Members must understand your health problems and work with your provider to develop agreed-upon goals (to the degree possible).
2. Members must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
3. Members must become involved in the decisions about your unborn child's care.
4. If members have a disagreement with the health plan, you must try first try to resolve it using the health plan's complaint process.
5. Members must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
6. Members must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. Members must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
8. Members must talk to your provider about your medications that are prescribed.
9. Members have a responsibility to provide information to Community First or its providers (to the degree possible) that is needed to provide care.

If members think they have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

XIII. 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 and Community First Health Plans' managed care contract with HHSC, 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 Provider's contract with Community First Health Plans, or any violation of Community First Health Plans' 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:

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 Health Plans becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against Community First Health Plans will be through Community First Health Plans' bankruptcy, conservatorship, or receivership estate.

2. The Provider understands and agrees that Community First Health Plans' Members may not be held liable for Community First Health Plans' debts in the event of the entity's insolvency.

3. The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) do not assume liability for the actions of, or judgments rendered against, Community First Health Plans, 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 Health Plans or any judgment rendered against Community First Health Plans. 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 Health Plans is prohibited from imposing restrictions upon the Provider's free communication with a Member about the Member's medical

conditions, treatment options, Community First Health Plans' referral policies, and other Community First Health Plans' policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

D. Provider Requirements, CHIP/CHIP PERINATAL/CHIP PERINATE Agreements and NPI

Network providers must inform both the MCO and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.

All Providers, both CHIP/CHIP-PERINATAL/CHIP-PERINATE must have a National Provider Identifier (NPI) in accordance with 45 C.F.R. Part 162, Subpart D.

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 anything of value to an officer or employee of HHSC or the State of Texas, as this is 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. Community First Health Plans may terminate a Provider's 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 $100,000 per occurrence and $300,000 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 Health Plans 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 Health Plans 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 11)**, the **Medical Record Documentation Guidelines (Exhibit 12)**, and the **Recommended Immunization Schedule (Exhibit 13)** 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 Health Plans' 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 Health Plans' medical record standards.

I. Practice Guideline Development

In an effort to provide and maintain quality health care and preventive service, Community First Health Plans 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/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans. If you are interested in joining any of these committees, please contact your Network Management Representative.

J. Pre-existing Conditions

Community First Health Plans is responsible for arranging for the provision of all covered services to each eligible Community First Health Plans' CHIP/CHIP-PERINATE Member beginning on the CHIP/CHIP-PERINATE 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 Health Plans 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 INFORMATION

1. REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT CHIP/CHIP-PERINATAL/CHIP-PERINATE

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

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

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, trails 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 CHIP/CHIP-PERINATAL/CHIP-PERINATE Services, 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 Health Plans or a Member to the HHSC Office of Inspector General.

To report waste, abuse, or fraud, choose one of the following:

Call the OIG Hotline at 1-800-436-6184

Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or

You can report directly to your health plan:

Community First Health Plans Health Plans
Director of Member Services
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
(210) 227-2347 or 1-800-434-2347

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, Texas. 78708-5200

To report clients:

Office of the Inspector General
General Investigations/Mail Code 1362
P.O. Box 85200
Austin, Texas 78708-5200

Fraud Hotline (800) 436-6184
Visit OIG website http://oig.hhsc.state.tx.us/ and click here to Report Waste, Abuse, and Fraud to complete the form online

http://www.hhsc.tx.us. And pick "Click Here to Report Waste, Abuse, and Fraud" to complete the on-line form:

4. Reporting Provider/Recipient Fraud, Waste and Abuse:

Community First Health Plans 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.

Community First Health Plans Health Plans Inc.
ATTN: Coding and Compliance Unit
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

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

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

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE AND CHIP

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

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.

- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
  - You can report directly to your health plan:
  - MCO's name
  - MCO's office/director address
  - MCO's toll free phone number

To report waste, abuse, or fraud, gather as much information as possible.

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

M. Coding and Compliance Unit

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

Community First Health Plans is committed to protect and preserve the integrity and availability of health care resources to our recipients, our healthcare partners and the general community. Community First Health Plans performs these activities through its Coding and Compliance Unit to detect, prevent and eliminate waste; abuse and fraud at the provider, recipient and health plan level. Community

First Health Plans 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, Community First Health Plans 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** 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 CHIP/CHIP-PERINATAL/CHIP-PERINATE services.

2. **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** 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.

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

N. Fraud and Abuse Compliance Program

Community First Health Plans is subject to all state and federal laws and regulations relating to fraud and abuse in health care. Community First Health Plans 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 Health Plans 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 Health Plans' 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.

XIV. CHIP/CHIP PERINATAL/CHIP PERINATE ENCOUNTER DATA BILLING AND CLAIM ADMINISTRATION

A. Where to Send Claim/Encounter Data?

The address for submitting CHIP/CHIP-PERINATAL/CHIP-PERINATE claims is:

Community First Health Plans Health Plans, Inc.
ATTN: Claims Department
P.O. Box 853927
Richardson, Texas 75085-3927

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

Community First Health Plans 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 ink/cartridge 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.

If you would like information on submitting your claims electronically, contact ***Availity***, our vendor for electronic filing at 1-800-282-4548. If you need additional information on electronic filing contact your Network Management Representative.

B. Claims forms to use? ?

Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE claims are processed within 30 days of receipt of the claim. CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 21.52C, Texas Insurance Code and Title 28 (Texas Administrative Code), Part 1, Chapter 21, Subchapter T, Rule § 21.2803, as such statute or regulations may be amended from time to time to be eligible for penalty payment.

C. Claims Submission

In order to submit a clean claim, Provider must provide the following information with the claim on the correct claims form depending on specialty:

1. CMS 1500

Claims must be filed on a **CMS 1500 (Exhibit 14)** with the following information:

a. Member's CHIP/CHIP-PERINATAL/CHIP-PERINATE ID 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 NPI (Box 17a)

h. ICD-10 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 when appropriate (Box 24d);

m. Charge of service (Box 24f)

n. Rendering provider 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);

b. NPI of the billing provider (Box 33b), which was released by The National Uniform Claim Committee (NUCC)

Primary insurance EOP must be attached, if applicable or claim will be denied for this information.

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

2. UB-04

Providers must be filed on a **UB-04 (Exhibit 15)** 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, marital status (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-10 Diagnosis 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 Health Plans 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 statue or regulation in a shorter timeframe.

D. Electronic Data Interface (EDI)

Community First Health Plans can now accept all professional and institutional claims through Electronic Data Interface (EDI), which is the preferred method of receipt. Community First Health Plans uses the health care clearinghouse ***Availity***.

Please follow the following processes when submitting EDI claims:

1. The preferred method of receipt of claims is electronically through EDI. Community First Health Plans uses ***Availity*** as the intermediary.

2. The Community First Health Plans' Availity **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 (972) 766-5480.

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 Health Plans. As Community First Health Plans implements this regulation and modifies its own processes, it will provide you notice of how such modifications affect the claims submission process.

Community First Health Plans 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 Health Plans is unable to provide 30 days' notice, Community First Health Plans 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 Health Plans shall adjudicate (finalize as paid or denied adjudicated) clean claims within 30 days from the date the claim is received by Community First Health Plans. Community First Health Plans 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. Electronic Funds Transfer (EFT)

Enrollment Process:

Community First Health Plans Health Plans' customers may elect to receive their payments thru Electronic Funds Transfer (EFT). The arrangement with *Emdeon* to deliver this service will require the provider to complete an enrollment process.

There is no cost to the provider for enrolling in for this service.
Emdeon provides payer remittance data electronically via *Emdeon* Payment Manager – ePayment Edition. With Payment Manager – ePayment Edition, staff can quickly search, view or print each remittance as needed. To enroll, simply follow the instructions outlined to begin the process. Please note there will be a 30 day print suppression for all customers.

New EFT Customers: (30 day print suppression from the date of enrollment)
Option 1: *Online*: Go to www.emdeon.com/eft.
Option 2: *Mail or Fax:* Go to www.emdeon.com/epayment to download y our EFT enrollment form and Fax or mail in your completed form to start realizing the benefits of electronic payments and remittance advises. Enrollee's must obtain a registration code prior to downloading the forms. To obtain a registration code, please contact *Emdeon* at -866-506-2830 option 1.
Option 3: *Telephone*: Contact *Emdeon* at 1-866-506-2830, select option 1 to start your enrollment process.

Existing EFT Customers: (30 day print suppression until August 30, 2011)
Existing *Emdeon* EFT customers and wish to be add Community First Health Plans Health Plans to their service, please call 1-866-506-2830 and select option 1, an *Emdeon* Enrollment Representative will assist you.

What is print suppression?
Print suppression means you will receive your Explanation of Payments via mail for 30 days from the date of enrollment. If you are not prepared to print your EOP's and need an extra time to print, simply call *Emdeon* at -866-506-2830 option 2 for a 15 day extension.

Who do I contact if I experience problems with my user ID or printing my EOP's?
Please contact *Emdeon* at 1-866-506-2830, option 1, an enrollment representative can assist you.

What if I am still experiencing problems after contacting *Emdeon*?

You may contact your Community First Health Plans' Network Management Representative for assistance.

Community First Health Plans 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 statue or regulation in a shorter timeframe.

F. Emergency Services Claims

Community First Health Plans' 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 Health Plans' 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 Health Plans 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 Health Plans 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 Health Plans 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 (Exhibit 16)

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.

H. Billing Members

By entering into an Agreement with Community First Health Plans, you have agreed to accept payment directly from us. Reimbursement from Community First Health Plans 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 Health Plans for rendering covered services.***

You have also agreed that in no event, including, but not limited to nonpayment by Community First Health Plans 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 Health Plans.

Community First Health Plans 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 HHSC Agency, or any Member to collect payment from HHSC, an HHSC 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 Health Plans.

2. Failure to submit a claim to Community First Health Plans for initial processing within the 95 day filing deadline.

3. Failure to submit a corrected claim within the 120 day filing re-submission period.

4. Failure to appeal a claim within the 120 day appeal period.

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

1. Filing Deadlines:

   a. Community First Health Plans must receive clean claims for CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans **accepts the following as proof of timely filing:**

   a. Certified mail receipt

b. Dated fax transmission confirmation with Community First Health Plans' fax number

c. Electronic confirmation from any clearinghouse such as ***Availity***

d. Log listing claims with member name and date of service if signed and dated by both the provider and a Community First Health Plans' representative.

3. Appeal Deadlines:

a. Providers have the right to appeal the denial of a claim by Community First Health Plans. Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Appeal Submission Form must be received by Community First Health Plans within ninety-five (95**)** days of the date of the **ORIGINAL** Explanation of Payment.

b. All appeals and or corrected claims must indicate "Appeal" or "Corrected Claim" on the re-submission. Community First Health Plans 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 Health Plans to:

Community First Health Plans Health Plans, Inc.
Attn.: Claims Appeal
Community First Health Plans
P.O. Box 853927
Richardson, Texas 75085-3927

iii. In writing through your Network Management Representative.

iv. In writing through HSM Department, if related to a notification or authorization issue.

v. Via Community First Health Plans' Provider Portal

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

J. Negative Balances

1. A negative balance may exist when Community First Health Plans attempts to recover an overpayment. Community First Health Plans has the right to recover overpayments made to providers. If Community First Health Plans is unable to recover an overpayment a negative balance is created.

2. If a negative balance exists on an Explanation Of Payment (EOP), maintain a copy of the EOP for future reference.

K. Coordination of Benefits

Coordination of Benefits is not included in the CHIP/CHIP-PERINATAL/CHIP-PERINATE Services.

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 Health Plans' 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 17)** 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 Health Plans 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 Health Plans. 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 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 Health Plans 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
P.O. Box 853927
Richardson, Texas 75085-3927

O. Claim Check

The analysis by ClaimCheck is based on procedure rules and coding schemes developed by the AMA and found in CPT-4 & ICD-10 manuals as they apply to medicine, surgery, radiology, laboratory, pathology and anesthesiology services. Many other resources also were used by ClaimCheck to develop the auditing system such as National Correct Coding Initiative (NCCI), CMS, specialty societies and specialty consultants. ClaimCheck is updated by its developers annually as new editions of CPT and ICD manuals become available.

ClaimCheck provides consistent and objective claim review. Some of the common oversights ClaimCheck 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

XV. CHIP/CHIP PERINATE/CHIP PERINATAL MEMBER ENROLLMENT AND DISENROLLMENT

A. Enrollment is 12 months eligibility.

To enroll in Community First Health Plans' health plan, the Member's permanent residence must be located within Community First Health Plans' service area. Administrative Services Contractor will electronically transmit to Community First Health Plans 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.**

For CHIP-Perinate, the mother of the CHIP Perinate has 15 calendar days from the time the enrollment packet is sent by the vendor to enroll in an MCO (where a choice is available)

Newborn Process:

All members of the household must remain in the same health plan until the latter of:

1. The end of the CHIP Perinatal member's enrollment period, or
2. The end of the traditional CHIP Program member's enrollment period. Co-payment, cost-sharing, and enrollment fees still apply to the children enrolled in the CHIP Program.

In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program members' information. Once the child's CHIP Perinatal service coverage expires, the child will be added to his or her siblings' existing CHIP program cases.

B. Re-Enrollment

At the beginning of the fifth month of coverage, Administrative Services Contractor will send a note to the family outlining the next steps for renewal or continuation of

coverage. Administrative Services Contractor will also send a notice to Community First Health Plans 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 Health Plans may facilitate re-enrollment through reminders to Members and other appropriate means. Failure of the family to respond to Administrative Services Contractor's renewal notice will result in disenrollment from Community First Health Plans and from CHIP/CHIP-PERINATAL.

C. Dis-Enrollment

1. CHIP/CHIP-PERINATE Members can be dis-enrolled from CHIP/CHIP PERINATE for any of the following reasons:

    a. "Aging-out" when a child turns nineteen

    b. Change in health insurance status, such as a child enrolling in an employer-sponsored health plan

    c. Failure to meet monthly cost sharing obligation

    d. Death of a child

    e. Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP/CHIP-PERINATE

    f. Immigration

    g. Increased income

    h. Provisional eligibility term

    i. Health plan change

    j. Not CHIP/CHIP-PERINATE eligible

    k. Child left household

2. Community First Health Plans has the limited right to request disenrollment of CHIP/CHIP-PERINATE Members from our health plan. The CHIP/CHIP-PERINATE Member may request the right to appeal such decision. The PCP will be responsible for directing the CHIP/CHIP-PERINATE Member's care until the disenrollment is made. A request to dis-enroll a Community First Health Plans CHIP/CHIP-PERINATE Member is ***acceptable*** under the following circumstances:

a. CHIP/CHIP-PERINATE Member misuses or lends their Community First Health Plans membership ID Card to another person to obtain services.

b. The CHIP/CHIP-PERINATE Member is disruptive, unruly, threatening or uncooperative to the extent that the CHIP/CHIP-PERINATE Member seriously impairs Community First Health Plans' or a provider's ability to service the CHIP/CHIP-PERINATE Member. However, this only occurs if the CHIP/CHIP-PERINATE Member's behavior is not due to a physical or behavioral health condition.

c. The CHIP/CHIP-PERINATE Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow Community First Health Plans to arrange for the treatment of the underlying medical condition.

3. Community First Health Plans CHIP/CHIP-PERINATE providers cannot take retaliatory action against a member who dis-enrolls from the Health Plan.

D. Plan Changes

1. A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

2. A CHIP Perinate mother in a family with an income at or below 185% of FPL maybe eligible to have the cost of the birth covered through Emergency Medicaid. Clients under 185% of FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.

3. A CHIP Perinate will continue to receive coverage through the CHIP program as a "CHIP Perinate Newborn" if born to a family with an income above 185% to 200 % FPL and the birth is reported to HHSC's enrollment broker.

4. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal Health Plan.

5. CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the

mother has 90 days to select another MCO.

6. When a Member of the household enrolls in a CHIP Perinatal all traditional CHIP Members in the household will be dis-enrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if the plan is different. All Members of household must remain in the same health plan until the latter of:

   (1) the end of the CHIP Perinatal Member's enrollment period,
   (2) the end of the traditional CHIP member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her sibling's existing CHIP case.

7. CHIP Perinatal Members may request to change health plans under the following circumstances:
   - for any reason within 90 days of enrollment in the CHIP Perinatal
   - If the Member moves into a different delivery area; and
   - for cause at any time

XVI. CHIP/CHIP PERINATAL/CHIP PERINATE SPECIAL ACCESS REQUIREMENTS

A. Interpreter/Translation Services

Community First Health Plans strives to be a culturally-sensitive organization and culturally-sensitive organization and has linguistic and interpreter services available for its CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Member, please contact Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Member Services Department at (**210) 358-6300** or **1-800-434-2347** from **8:00 am to 5:00 pm Monday through Friday**.

Community First Health Plans also provides education related to the linguistic and cultural needs and characteristics of CHIP/CHIP-PERINATAL/CHIP-PERINATE Members upon request from Community First Health Plans' participating providers.

B. Community First Health Plans/Provider Coordination

Community First Health Plans and CHIP/CHIP-PERINATAL/CHIP-PERINATE Providers should make reasonable efforts to accommodate CHIP/CHIP-PERINATAL/CHIP-PERINATE Members with special access requirements.

C. Reading/Grade Level Consideration

Community First Health Plans publishes Member information at a sixth grade reading level so that it can be easily interpreted by the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member.

D. Cultural Sensitivity

Community First Health Plans 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 Health Plans' 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/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans. The decision to provide treatment is between the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member and the attending physician.

Note: Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. Community First Health Plans does not specifically award practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization. To make UM decisions, Community First Health Plans uses the requesting practitioner's recommendation and nationally recognized criteria and guidelines, and applies the criteria in a fair, impartial, and consistent manner that serves the best interest of our Members. To ensure that Members receive the most appropriate healthcare, Community First Health Plans reviews your care before, during, and after you receive it to ensure it is covered. Pre-service review occurs before you receive care and post-service review occurs before the claim is paid when you receive care that was not authorized in advance. Generally, the member's practitioner requests prior authorization from Community First Health Plans before you receive care; however, it is the member's responsibility to make sure that they are following Community First Health Plans rules for accessing care. If you are obtaining care from a non-network provider, call (210) 358-6070 or toll-free at 1-800-434-2347 to request Community First's review of your care. Out-of-network care that is not approved in advance by Community First is not covered. We also review your care while you are in the hospital and work with the hospital staff to help ensure you have a smooth transition to home or your next care setting. Our experienced clinical staff reviews all requests. Member needs that fall outside of standard criteria are reviewed by our physician staff for plan coverage and medical necessity. Community First Health Plans approves or denies services based upon whether or not the service is medically needed and a covered benefit.

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/CHIP-PERINATAL/CHIP-PERINATE Members;

2. Allowing us to review medical and financial records concerning care rendered to our CHIP/CHIP-PERINATAL/CHIP-PERINATE Members;

3. Participating with us in discharge planning, disease management, and case management;

4. Participating with our Community First Health Plans' committee proceedings when appropriate.

B. Authorization

Community First Health Plans currently requires preauthorization for the services listed in**.** The list of services requiring preauthorization is subject to change Community First Health Plans will provide at least 90 days' notice of changes in the list of authorized services.

Note*:* Community First Health Plans 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 Health Plans. All services listed on the preauthorization list 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/CHIP-PERINATAL/CHIP-PERINATE Members for covered services. Community First Health Plans will not honor retro-active requests for authorization.

PCPs and specialists can call our Health Services Management Department at **(210) 358-6060 or 1-800-434-2347** to obtain preauthorization, or fax the completed Texas Referral/Authorization form to **(210) 358-6040 or 1-800-343-2347**. The Health Services Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. CT. After hours and on weekends or holidays Community First Health Plans 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 Health Plans 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-10 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 Health Plans' 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 Health Plans' Medical Director for final review. If we do not receive the required information, the services will be denied.

Community First Health Plans 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/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans' network provider. Community First Health Plans' 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 Health Plans. 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 Health Plans' network provider. Use of a non-participating provider requires preauthorization by Community First Health Plans' 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 Health Plans' 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 Health Plans does not require preauthorization for court mandated inpatient psychiatric care for CHIP/CHIP-PERINATE 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/CHIP-PERINATE Members may self-refer for the following services:

- Obstetrical and/or Gynecological Services to a participating provider (except for those CHIP/CHIP-PERINATE Members in a Limited Provider Network).
- Select and have access to a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Service other than surgery.
- 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 Health Plans' CHIP/CHIP-PERINATE Member has been properly notified of the private pay status, the provider should not seek payment from an eligible Community First Health Plans' CHIP/CHIP-PERINATE Member. A Provider cannot bill a Community First Health Plans' CHIP/CHIP-PERINATE Member for those reasons provided in the. You should also include a copy of Community First Health Plans Member's acknowledgement that they are a private pay patient.

F. Quality Management Improvement Program/Behavioral Health Medical Records

Community First Health Plans' Quality Management and Improvement Program (QMIP) 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.
Provider understands and agrees that any provider performance data gathered by Community First Health Plan as part of QMIP program may be published on its website for other such reports.

XVIII. CASE MANAGEMENT

A. Introduction

Community First Health Plans is committed to providing the most appropriate and efficient level of service to our customers. Community First Health Plans 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 Health Plans' Case Management Program emphasizes the importance of communication between PCPs, specialists, and Community First Health Plans.

Community First Health Plans' Case Management Program or its designee provides case management services to Community First Health Plans' CHIP/CHIP-PERINATAL/CHIP-PERINATE Members. When a CHIP/CHIP-PERINATAL/CHIP-PERINATE Member is identified or referred to Community First Health Plans' 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/CHIP-PERINATE Members. Community First Health Plans 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/CHIP-PERINATE Member's PCP. Some case management candidates are initiated through a review of Community First Health Plans' utilization data.

B. Functions of the Case Management Program

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/CHIP-PERINATAL/CHIP-PERINATE 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/CHIP-PERINATAL/CHIP-PERINATE Member.
4. Inform health care professionals, CHIP/CHIP-PERINATAL/CHIP-PERINATE 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/CHIP-PERINATE member and family.
6. Identify aberrant practices and submit to the appropriate personnel.
7. Explain benefit coverage to CHIP/CHIP-PERINATAL/CHIP-PERINATE Member and families.
8. Facilitate linkages to appropriate community resources.

Community First Health Plans' 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 Health Plans' CHIP/CHIP-PERINATE 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/CHIP-PERINATE Administrative Services Contractor, or Community First Health Plans may preliminarily identify a CCSHCN. Community First Health Plans 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.

XIX. 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 Health Plans 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 Health Plans. 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 18**) to:

   Community First Health Plans 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 Plans Health Educator at (210) 358-6144.
4. The standard Authorization form for Community First Health Plans 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 Health Plans participated in the pilot and then took the initiative to develop outreach mechanisms not only for the STAR population, but to include the CHIP/CHIP-PERINATE and Commercial membership. Community First Health Plans 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

Asthma*Matters* is an initiative developed by Community First Health Plans 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 Health Plans 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 Asthma*Matters* 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 Asthma*Matters* 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 Health Plans 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 Health Plans 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 Plans' 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 Health Plans 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 Health Plans 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 Health Plans has worked with the Texas Department of State Health Services, 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 Health Plans' staff is available to outreach to CHIP/CHIP-PERINATAL 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 Health Plans 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 Health Plans conducted a survey of primary care provider needs regarding care coordination, access to Community First Health Plans 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 **Special Health Care Needs Member Survey (Exhibit 19)**.

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 (210) 358-6040.

XX APPEALS

A. Adverse Determination

If you wish to appeal a decision made by Community First Health Plans that the health care services proposed to be furnished or furnished to a CHIP/CHIP-PERINATAL/CHIP-PERINATE Member are not medically necessary, you or the CHIP/CHIP-PERINATAL/CHIP-PERINATE 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 Health Plans will send the appealing party a letter acknowledging the date of Community First Health Plans' receipt of the appeal. This letter will include a reasonable list of documents needed to be submitted to Community First Health Plans for the appeal.

2. When Community First Health Plans receives an oral appeal of adverse determination, Community First Health Plans 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 Health Plans.

4. After Community First Health Plans has reviewed the appeal of the Adverse Determination, Community First Health Plans will provide written notification to the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member, and the CHIP/CHIP-PERINATAL/CHIP-PERINATE Member's physician or health care provider explaining the resolution of the appeal. Community First Health Plans 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 an 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 Health Plans, 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 Health Plans 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 Health Plans' 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 Health Plans' 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 Health Plans 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 Health Plans will, by registered or certified mail, inform you of Community First Health Plans' 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, Alaskan Natives	$0	$0	$0	$0	$0	$0
At or below 100%	$3	$3	$15	$0	$3	1.25% family annual gross income
100%-150%	$5	$5	$35	$0	$5	1.25% family annual gross income
151%-185%	$12	$50	$70	$5	$20	2.5% cap of family annual gross income
186%-200%	$25	$75	$125	$10	$35	2.5% cap of family annual gross income

No co-payments for CHIP Perinatal, CHIP Perinate, and CHIP members who are Native Americans or Alaskan Natives. Additionally for CHIP members, there is no cost sharing on benefits for well-baby and well-child services, preventive services, or pregnancy related assistance.

B. PCP Request for Member Transfer

The PCP must submit a request to Community First Health Plans in writing to transfer a Community First Health Plans CHIP/CHIP-PERINATE Member from the PCP's practice. Complete a Community First Health Plans' **Provider Request for Member Transfer (Exhibit 20)** form and return the completed form to your Community First Health Plans Provider Relations Representative. If you have any questions regarding this process, please contact Community First Health Plans' Network Management Department at (**210) 358-6030**.

C. Member Request for PCP Change

A CHIP/CHIP-PERINATE Member's parent or guardian may call Community First Health Plans to request a change in PCP. If a CHIP/CHIP-PERINATE 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 Health Plans provides CHIP/CHIP-PERINATE 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 as PCP

E. **Transition of Care** involves any active course of treatment rendered by a non-participating specialist prior to a new CHIP/CHIP-PERINATE 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/CHIP-PERINATE Members that have either disabilities or chronic/complex medical or behavioral conditions. Through collaboration with Community First Health Plans' nurse case managers, CHIP/CHIP-PERINATE 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 Health Plans may allow a participating specialist currently treating a CHIP/CHIP-PERINATE 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 to (**210) 358-6040**. Community First Health Plans will coordinate with Texas Department of Family and Protective Services (TDFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

G. Release of Information

Provider must obtain a signed authorization for release of information from CHIP/CHIP-PERINATAL/CHIP-PERINATE Members. You may use the standard CMS 1500/UB04 or develop your own form. If you develop your own form, the release should allow you to disclose information to Community First Health Plans.

This will enable us to process claims and perform our Utilization Management and Quality Management functions.

H. Member Privacy

Both Community First Health Plans and all Providers in the Community First Health Plans 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 Health Plans 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 Health Plans panel status, please notify Community First Health Plans' 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 Health Plans, you must notify Community First Health Plans in writing at least sixty (60) days prior to any action by you to limit or close your panel to Community First Health Plans' CHIP/CHIP PERINATE Members. Notifications less than sixty (60) days to limit or close your panel will be considered on a case-by-case basis.

J. Pharmacy Provider Responsibilities

- Adhere to the Formulary and Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible

K. Provider Under Investigation

Community First Health Plans 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 Health Plans has been notified of such investigation, exclusion or suspension.

L. Balance Billing Members

By entering into an Agreement with Community First Health Plans, you have agreed to accept payment directly from us. Reimbursement from Community First Health Plans 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 Health Plans for rendering covered services.

You have also agreed that in no event, including, but not limited to nonpayment by Community First Health Plans 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 Health Plans.

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 Health Plans.
2. Failure to submit a claim to Community First Health Plans 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 95 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 Health Plans CHIP/CHIP-PERINATAL/CHIP-PERINATE 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." **Member/Client Acknowledgement Statement (Exhibit 21)**

N. Private Pay 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 Health Plans for Services provided to me."
Private Pay Agreement Form (Exhibit 7)

O. CHIP/CHIP PERINATE 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/CHIP-PERINATE. 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/CHIP-PERINATE providers to assure an adequate inventory of vaccines for CHIP/CHIP-PERINATE 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/CHIP-PERINATE eligible children regarding the CHIP/CHIP-PERINATE vaccine program.

CHIP/CHIP-PERINATE providers must complete and submit the vaccine accounting documents to HHSC. Documentation required tracks the requirements for the **Texas Vaccines for Children Program (Exhibit 22)** with forms designated as "CHIP/CHIP-PERINATE".

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled providers for administration to individual's birth through 18 years of age.

Qualified Medicaid and CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.

Community First Health Plans will pay for TVFC Program provider's private stock of vaccines, but only when the TVFC posts a message on its website that no stock is available. In that case, providers should submit claims for vaccines with U1 modifier, which indicates private stocks. Providers should only submit claims for private stock until the vaccine is available from TVFC again. Community First Health Plans will no longer reimburse providers for private stock when the TVFC stock is replenished.

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 Health Plans 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, 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/defaul.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

Provides 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

1. Community First Health Plans' 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 submit the **Tuberculosis Report of Case and Patient Services (Exhibit 23)** to the Texas Department of State Health Services (DSHS) or may be posing a public health threat.

2. Community First Health Plans' Providers must coordinate with LTCHA and report any Community First Health Plans' CHIP/CHIP-PERINATE Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

3. Community First Health Plans' 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 Health Plans' 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 Health Plans" 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 (CDCP), and DSHS policies and standards.

6. Community First Health Plans' 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 Health Plans' Nurse Coordinators work with the servicing provider in coordinating a post-discharge plan for follow-up DOT with the local TB program. Community First Health Plans 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.