



## **Bexar Service Area**

### **Service Area includes:**

**Atascosa, Bandera, Bexar, Comal, Guadalupe,  
Kendall, Medina and Wilson Counties**

## **Provider Manual September 2015**

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

**Website  
[WWW.CFHP.COM](http://WWW.CFHP.COM)**

<b>I.</b>	<b>INTRODUCTION.....</b>	<b>7</b>
	A. Background and Objectives of Program .....	7
	B. Quick Reference Phone List.....	9
	C. Role of Primary Care Physician (Medical Home).....	10
	D. Role of Specialty Care Physician .....	12
	E. Network Limitations .....	12
	F. Providers for STAR Members with Disabilities, Children with Special Health Care Needs (CSHCN) and/or Chronic/Complex Conditions.....	12
	G. Children of Migrant Farmworkers.....	13
	H. Non-Discrimination by Participating Provider .....	13
	I. Medical Record Standards.....	13
	J. Role of Pharmacy .....	16
	K. Role of Main Dental Home .....	17
<b>II.</b>	<b>LEGAL AND REGULATORY .....</b>	<b>18</b>
	A. Law, Rules and Regulations .....	18
	B. Liability .....	19
	C. Medical Consent Requirements .....	19
	D. Member Communication .....	19
<b>III.</b>	<b>COVERED SERVICES.....</b>	<b>21</b>
	A. Texas Health Steps Services .....	21
	B. Medicaid Managed Care Covered Services.....	41
	C. Coordination with Non-Medicaid Managed Care Covered Services (Non-Capitated Services).....	46
	D. Texas Agency Administered Programs and Case Management Services.....	46
	E. Essential Public Health Services .....	49
	F. Family Planning Services .....	64
<b>IV.</b>	<b>BEHAVIORAL HEALTH .....</b>	<b>73</b>
	A. Definition .....	73
	B. Behavioral Health Covered Services .....	73
	C. PCP Requirements for Behavioral Health.....	73
	D. Behavioral Health Services .....	73
	E. Behavioral Health Screening and Assessment.....	77
	F. Summary Reports to Primary Care Providers .....	77
<b>V.</b>	<b>QUALITY MANAGEMENT.....</b>	<b>78</b>
	A. Delegation of QMIP Activities .....	78
	B. Practice Guideline Development.....	78
	C. Focus Studies and Utilization Management Reporting Requirements.....	79

<b>VI.</b>	<b>PROVIDER RESPONSIBILITIES.....</b>	<b>80</b>
	A. PCP (Medical Home) Responsibilities.....	80
	B. Availability and Accessibility .....	81
	C. Plan Termination Process .....	84
	D. Members right to designate an OB/Gyn .....	85
	E. Advanced Directive .....	85
	F. Referral to Specialists and Health Related Services .....	86
	G. PCP & Behavioral Health Related Services .....	86
	H. Referral to Network Facilities and Contractors.....	86
	I. Access to Second Opinion.....	86
	J. Specialty Care Provider Responsibilities.....	87
	K. Verify Member Eligibility and/or Authorization for Services .....	89
	L. Continuity of Care .....	93
	M. Transition of Care.....	94
	N. Medical Records Documentation Guidelines .....	94
	O. Justification Regarding Out of Network Referrals.....	96
	P. Optometry and Ophthalmology Services.....	97
	Q. Access to Medication.....	97
	R. How to Help a Member Find Dental Care.....	97
	S. Confidentiality.....	98
	T. Fraud and Abuse.....	98
	U. Insurance .....	100
	V. Marketing .....	100
	W. Provider Network Requirements .....	100
	X. Credentialing and Recredentialing.....	100
	Y. Updates to Contact Information .....	103
<b>VII.</b>	<b>COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS).....</b>	<b>104</b>
<b>VIII.</b>	<b>ROUTINE, URGENT AND EMERGENCY SERVICES .....</b>	<b>105</b>
	A. Definitions.....	105
	B. Emergency Transportation .....	107
	C. Non-Emergency Transportation.....	107
	D. Member/Client Acknowledgement Statement.....	108
	E. Private Pay Form Agreement .....	109
	F. Emergency Prescription Supply .....	110
<b>IX.</b>	<b>PROVIDER COMPLAINTS/APPEALS PROCESS.....</b>	<b>111</b>
	A. Provider Complaints to Community First Health Plans .....	111
	B. Provider Appeals to Community First Health Plans .....	111
	C. Provider Complaint Process to HHSC.....	113
<b>X.</b>	<b>MEMBER COMPLAINT/APPEAL PROCESS .....</b>	<b>114</b>
	A. Member Complaint/Appeal Process.....	114
	B. Member Appeals .....	114

C. Member Expedited Appeal .....	115
D. State Fair Hearing Information .....	116
<b>XI. MEMBER ELIGIBILITY AND ADDED BENEFITS .....</b>	<b>118</b>
A. Eligibility .....	118
B. Verifying Eligibility .....	118
C. Benefits .....	119
D. Value Added Services .....	120
E. Involuntary Disenrollment .....	123
<b>XII. MEMBER RIGHTS AND RESPONSIBILITIES .....</b>	<b>124</b>
A. Member Rights .....	124
B. Member Responsibilities .....	125
C. Can a Member Ask For a State Fair Hearing? .....	126
D. Self Referrals .....	127
E. Member's Right to Designate an OB/Gyn .....	127
F. Fraud Reporting .....	128
<b>XIII. ENCOUNTER DATA, BILLING AND CLAIMS</b>	
<b>ADMINISTRATION .....</b>	<b>137</b>
A. Where to Send Claims/Encounter Data .....	137
B. Claim Form to use .....	137
C. Monthly Capitation Services .....	138
D. Emergency Service Claims .....	139
E. Pharmacy Claims .....	139
F. No Co-payments for Medicaid Managed Care Members .....	140
G. Billing Members .....	140
H. Time Limit for Submission of Claims .....	141
I. Claims Payments and Payment Methodology .....	142
J. EOP, Duplicate Checks and Cancelled Check Requests .....	143
K. Special Billing .....	143
L. Billing and Claims Administration .....	144
M. Claims Questions/Appeals .....	146
<b>XIV. MEMBER ENROLLMENT AND DISENROLLMENT FROM</b>	
<b>COMMUNITY FIRST HEALTH PLANS .....</b>	<b>148</b>
A. Enrollment .....	148
B. Automatic Re-enrollment .....	148
C. Disenrollment .....	148
D. STAR Member PCP Change .....	149
<b>XV. SPECIAL ACCESS REQUIREMENTS .....</b>	<b>150</b>
A. General Transportation and Ambulance/Wheelchair Van .....	150
B. Interpreter/Translation Services .....	150
C. CFHP and Provider Coordination .....	150
D. Reading/Grade Level Consideration .....	150

<b>E. Cultural Sensitivity .....</b>	<b>151</b>
<b>F. Children with Complex and Special Health Care Needs.....</b>	<b>151</b>
<b>XVI. UTILIZATION MANAGEMENT .....</b>	<b>152</b>
<b>XVII. PREVENTIVE HEALTH AND DISEASE MANAGEMENT</b>	<b>153</b>

## **EXHIBITS**

<b>Exhibit 1</b>	<b>Request for Continuity Transition Care</b>
<b>Exhibit 2</b>	<b>Category Codes and Type Programs</b>
<b>Exhibit 3</b>	<b>Texas Benefits Medicaid Card</b>
<b>Exhibit 4</b>	<b>Community First Health Plans ID Card</b>
<b>Exhibit 5</b>	<b>Provider Request for Transfer</b>
<b>Exhibit 6</b>	<b>Request for Increase in 1500 Capacity</b>
<b>Exhibit 7</b>	<b>Texas Referral/Authorization Form</b>
<b>Exhibit 8</b>	<b>Complex Neonate Acuity of Service Matrix</b>
<b>Exhibit 9</b>	<b>Tuberculosis Report of Case and Patient Services</b>
<b>Exhibit 10</b>	<b>Texas Health Steps Periodicity Schedule</b>
<b>Exhibit 11</b>	<b>Sterilization Consent</b>
<b>Exhibit 12</b>	<b>Behavioral Health Request for Authorized Services</b>
<b>Exhibit 13</b>	<b>Psychological Testing Request Form</b>
<b>Exhibit 14</b>	<b>Member Education Request Form</b>
<b>Exhibit 15</b>	<b>Medical Record Review Tool</b>
<b>Exhibit 16</b>	<b>Member/Client Acknowledgement Statement</b>
<b>Exhibit 17</b>	<b>Preventive Services for Adults</b>
<b>Exhibit 18</b>	<b>Consent to use Physician Assistant/Nurse Practitioner</b>
<b>Exhibit 19</b>	<b>CMS 1500 Claim Form and Instruction Table</b>
<b>Exhibit 20</b>	<b>UB 04 Claim Form and Instruction Table</b>
<b>Exhibit 21</b>	<b>Private Pay Agreement</b>
<b>Exhibit 22</b>	<b>Explanation of Payment (EOP)</b>
<b>Exhibit 23</b>	<b>Provider Complaint Form</b>
<b>Exhibit 24</b>	<b>Claim Appeal Submission Form</b>
<b>Exhibit 25</b>	<b>Care Plan for Children with Complex Needs</b>
<b>Exhibit 26</b>	<b>Medicaid Eligibility Verification Form (H 1027-A)</b>
<b>Exhibit 27</b>	<b>Current Immunization Schedule</b>
<b>Exhibit 28</b>	<b>Infectious Disease Report</b>
<b>Exhibit 29</b>	<b>Blood Lead Screening and Testing Guidelines</b>

## I. INTRODUCTION

Welcome to the Community First Health Plans, Inc. STAR Network.

### A. Background and Objectives of Program

Community First Health Plans' **STAR (State of Texas Access Reform)** is a managed care option of the STAR Program for Medicaid clients. The objectives of the STAR Program are to improve the access to care for Members to increase the quality and continuity of care for Members, to decrease the inappropriate usage of the health care delivery system such as Emergency room visits for non-emergencies, to achieve cost-effectiveness and efficiency for the State and to promote provider and member satisfaction. Community First Health Plans is able to ensure these objectives are accomplished because of its diverse, fully credentialed network of physicians, allied health care providers, ancillary providers and hospitals.

Community First Health Plans' network is comprised of physicians (primary care physicians and specialists), allied and ancillary health care providers, hospitals and other facilities selected to provide quality health care to our STAR Members. The Primary Care Physician (PCP) is responsible for managing the overall medical care of patients, and for coordinating referrals to specialists and inpatient/outpatient facilities. A PCP is a Community First Health Plans STAR provider with one of the following specialties: General Practice, Family Practice, Internal Medicine, Obstetrics and Gynecology (pregnant women only), Pediatrics, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). In addition, Community First Health Plans STAR members can access contracted Advance Practice Nurses, Physician Assistants, and Certified Nurse Midwives practicing under the supervision of a physician for appropriate covered services.

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

We will mail updates to your office to advise you of any changes/updates to this manual. In addition, Community First Health Plans will publish and distribute a semi-annual newsletter to all network physicians and providers. The newsletter will include information such as STAR services, policies and procedures, statutes, regulations, and claims processing information. Community First Health Plans also utilizes fax alerts, banner messages, special mailings and our web site as additional means to communicate changes/updates to you and your staff.

Following the initial orientation session for STAR network physicians and providers, we will have ongoing training sessions when requested by the provider or deemed necessary by Community First Health Plans or the Texas Health and Human Services Commission (HHSC). Prior to the effective date of the renewal of our agreement with HHSC, Community First Health Plans will schedule provider orientations for existing providers to review STAR program requirements including changes to covered services, authorization requirements and claims submission procedures and/or appeal timeframes.

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 may be spoken by our STAR Members, such as Vietnamese. 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) 358-6060, or 800-434-2347. After hours and weekend, requests for interpreter services are answered by and arranged for through Community First Health Plans' 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
Urgent Care	(210) 227-2347
Behavioral Health Authorization /Case Management	(210) 358-6100 option 2 1-800-434-2347 option 7
Behavioral Health Fax	(210) 358-6387
NICU Fax	(210) 358-6382
Member Services	(210) 358-6060
Eligibility/Benefits Verification	
Interpreter Services - Sign and language	
Member Services Fax .....	(210) 358-6099
TDD (for the hearing impaired)	(210) 358-6080 1-800-390-1175
Network Management	(210) 358-6030
Claims Information	(210) 358-6200
Claims Fax	(210) 358-6199
Electronic Claims	Availity Payor ID: COMMF
Nurse Advice Line-After Hours	(210) 358-6060
Preventive Health & Disease Management	1-800-434-2347
Community Outreach Agencies	(210) 358-6159
Pharmacy	(toll free) 1-866-333-2757
Dental Inquiries	Toll free 800-516-0165 – DentaQuest Toll free 800-494-6262 MCNA Dental

After hours calls to Community First Health Plans are forwarded to the Nurse Advice Line.

### C. The Role of the Primary Care Physician.

Our PCPs play an integral role in helping us meet the objectives of the STAR Program. The program places its main focus on the total well-being of the Member while providing a "medical home" where the Member can readily access preventive health care services and treatment, as opposed to episodic health crisis management. Members will also be encouraged to become more involved in their own health care, and maintenance of their own wellness. The PCP is responsible for teaching STAR Members how to use available health services appropriately.

The PCP will provide preventive health services in accordance with the program, and related medical policies. They will also coordinate the provision of all covered services to STAR Members, initiate referrals to network specialty care physicians, network facilities and allied health care providers, monitor the Member's progress, facilitate the Member's return to the PCP when medically appropriate, and educate Members and their families regarding their medical care needs. The PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. It is the responsibility of the PCP to contact Community First Health Plans to verify Member eligibility and to obtain authorizations for covered services as appropriate.

PCPs must provide preventive care:

- To children under age 21 in accordance with American Academy of Pediatrics recommendations for Texas Health Steps periodicity schedule published in the Texas Health Steps Manual section, Children's handbook;
- To adults in accordance with the U.S. Preventive Task Force ....requirements.

A PCP must:

- Assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed;
- Coordinate Members' care with specialty care providers after referral;
- Serve as a Medical Home to Members.

The PCP must obtain the STAR Members consent when seeking services from a Physician Assistant or Nurse Practitioner (**Exhibit 18**).

The PCP will provide, or arrange for the provision of, covered services and/or telephone consultations during normal office hours as well as on an emergency basis, 24 hours a day, seven days a week. It is important to educate the Members to seek services from their designated PCP BEFORE accessing other specialty health care services with the following exceptions:

- Behavioral Health services
- Emergency services
- Obstetric/Gynecological services
- Family Planning
- Texas Health Steps
- Case Management for Children and Pregnant Women (CPW)
- School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitation Services (DARS)
- DSHS case management
- Department of Aging and Disability Services (DADS) case management
- Texas Health Steps Dental
- MHMR Services
- Routine Vision services

The PCP is responsible for arranging and coordinating appropriate referrals to other physicians and/or health care providers and specialists and for managing, monitoring, and documenting the services of other providers.

The PCP is responsible for the appropriate coordination and referral of Members for the following services:

- CPW case management services
- DARS case management services
- ECI case management services
- MR targeted case management
- SHARS
- Texas Commission for the Blind case management services
- Texas Health Steps medical case management
- Texas Health Steps dental (including orthodontics)
- Community First Health Plans Pharmacy Benefit through *Navitus*

### **Confidentiality**

The Provider must treat all information that is obtained through the performance services included in this 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.

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

The 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.

#### **Provider Request For Member Transfer**

The PCP must submit Community First Health Plans' Provider Request for Member Transfer form (**Exhibit 5**). If you have any questions regarding this process, please contact Community First Health Plans' Network Management Department.

#### **PCP STAR Member Capacity (PCP's Only)**

If a PCP wishes to limit or expand panel capacity, the PCP must contact Community First Health Plans Network Management Department. PCP's do not have panel size limitations; however, if increasing capacity greater than 1,500, a PCP must complete a Request for Increase in 1500 Capacity form (**Exhibit 6**) and submit to Community First Health Plans Network Management Department.

### **D. The Role of the Specialty Care Physician**

The specialty care physician is responsible for providing medically necessary services to Community First Health Plans STAR Members who have been referred by their PCPs for specified treatments and/or diagnostic services. **Specialists must verify the eligibility of the referred Member prior to rendering services.** If additional visits or services are necessary, the specialist may request authorization to provide these services or arrange for services by contacting Community First Health Plans' Health Services Management Department. 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 and specialist medical records.

### **E. Network Limitations**

A STAR Member may be assigned to a PCP who is part of a Limited Provider Network (an association of health professionals who work together to provide a full range of health care services). If a STAR Member selects a PCP or is assigned to 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 STAR Member may not be allowed to receive service from any physician or health care professional that is not part of the PCP's network (excluding OB/Gyn and Behavioral Health providers).

### **F. Providers for STAR Members with Disabilities, Children with Special Health Care Needs (CSHCN), and/or Chronic/Complex Conditions**

On an individual case basis, Community First Health Plans may allow a network specialist currently treating a STAR Member with disabilities or chronic /complex conditions or who is identified as a CSHCN member, to serve in the capacity of a PCP for that STAR member. The network specialist must agree to perform all PCP duties, and such duties must be within the scope of the participating specialist's certification. Network specialists wishing to become a PCP for STAR Members with disabilities, CSHCN, or chronic/ complex conditions must complete the **Request for Continuity/Transition of Care** form (**Exhibit 1**) and submit the form to Community First Health Plans' Health Services Management Department for review. To obtain further assistance in this process, please contact the Health Services Management Department at **(210) 358-6050**.

#### **G. Children of Migrant Farmworkers**

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup. Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

#### **H. Non-Discrimination by Participating Provider**

According to your contract with Community First Health Plans, you as a network provider agree to comply with the following requirements:

- Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the American with Disabilities Act of 1990, and all the requirements set forth by the regulations in carrying out these acts and all amendments to the laws and regulations.
- Medical records comply with Texas Health and Safety Code Section 85.113 (relates to workplace and confidentiality guidelines regarding AIDS and HIV).
- Regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973

#### **I. Medical Record Standards**

Community First Health Plans requires all providers to create and keep appropriate medical records in compliance with generally accepted medical records standards and all medical records must be kept for at least five (5) years, except for records of rural health clinics, which must be kept for a period of six (6) years from the date of service and Federally Qualified Health Clinics, which must be kept for a period of ten (10) years from the date of service.

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

The Provider agrees to provide at no cost to the Texas Health and Human Services Commission (HHSC):

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

Upon receipt of a record review request, a provider must provide, at no cost to the requesting agency, the Health and Human Services Commission, Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions. The records must be provided within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, the provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.

- All information required under Community First Health Plan's managed care contract with HHSC, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the contract
- 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.

The records must reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include the following requirements:

- Patient identification information. Each page or electronic file in the record contains the patient's name or patient ID number.
- Personal/biographical data, including: age; sex; address; employer; home and work telephone numbers; and marital status.
- All entries are dated and author identified.
- The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- Allergies: Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
- Past Medical History (for patients seen three or more times). Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
- Immunizations. For pediatric records there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Diagnostic information.
- Medication Information (includes medication information/instruction to member).
- Identification of current problems. Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical records.
- Member is provided basic teaching/instructions regarding physical and/or behavioral health condition.
- Smoking/Alcohol/Substance Abuse. Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.
- Consultation, Referrals and Specialist Reports. Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
- Hospital Discharge Summaries. Discharge summaries are included as part of the medical record for: (1) all hospital admissions, which occur while the patient is enrolled with the Contractor, and (2) prior admissions as necessary. Prior admissions as necessary pertain to admissions, which may have occurred prior to Member being enrolled with the Contractor, and are pertinent to the

Member's current medical condition.

- Advance Directive. For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- A written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.
- Written procedures for release of information and obtaining consent for treatment.
- Documentation of evidence and results of medical, preventive, and behavioral health screening.
- Documentation of all treatment provided and results of such treatment.
- Document of the team members involved in the multidisciplinary team of a Member needing specialty care.
- Documentation in both the physical and behavioral health records of integration of clinical care.
- Documentation to include: Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated.
- Screening and referral by behavioral health providers to PCPs when appropriate.
- Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
- At least quarterly (or more often if clinically indicated), a summary of status/progress from the behavioral health provider to the PCP.
- A written release of information, which will permit specific information sharing between providers.
- Documentation that behavioral health professionals are included in primary and specialty care service teams described in the contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- Providers are required to submit information for the Health Passport.

### **Release of Information**

You should obtain from STAR Members a signed authorization for release of information. 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 and the Department of State Health Services (DSHS). This will enable us to process claims and perform our utilization management and quality management functions.

## **J. Role of Pharmacy**



The pharmacy is responsible for providing pharmaceutical services to Community First Health Plans STAR Members. Pharmacies must verify the eligibility of the Member prior to rendering services. Pharmacies are responsible for:

- Adhere to the Formulary and Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible
- Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits

**K. Role of 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.

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

## **II. LEGAL AND REGULATORY**

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's contract and Community First Health Plans' managed care contract with HHSA, the HMO Program, and all persons or entities receiving state federal funds. The provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Providers contract, or any violation of the 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**

Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Provider Contract and the Community First Health Plans' contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to the Provider contract, 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.

1. Provider understands and agrees the following laws, rules, and regulations, and all subsequent amendments or modifications thereto, apply to the Provider contract:
  - a. environmental protection laws:
    - i. 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;
    - ii. 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;
    - iii. 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");
    - iv. State Clean Air Implementation Plan (42U.S.C. §740 et seq.)

regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and  
v. 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:

- a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
- b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- c. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- d. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- e. Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);
- f. Executive Order 13279, and its implementing

**B. Liability**

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.

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 Community First Health Plans' insolvency.

Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, Community First 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. Medical Consent Requirements**

Providers must comply with medical consent requirements in Texas Family Code §266.004, which require the Member's Medical Consenter to consent to the provision of medical care. Providers must notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Texas Family Code §266.009.

**D. Member Communication**

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.

### III. COVERED SERVICES

#### A. Texas Health Steps Services

##### Overview

The Texas Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid recipients who are ages of birth through 20 years of age. In Texas, the EPSDT program is known as Texas Health Steps (Texas Health Steps). Texas Health Steps is administered by the Department of State Health Services (DSHS).

Community First Health Plans' PCPs must:

1. either be enrolled as Texas Health Steps providers or refer Members due for a Texas Health Steps check-up to a Texas Health Steps provider;
2. refer Members for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps check-up, including the developmental and behavioral components of the screening;
3. submit information from the Texas Health Steps forms and documents to the members Medical Home.

Through outreach, Texas Health Steps staff, or contractors encourage STAR Members to use Texas Health Steps preventive medical checkup services when they first become eligible for Medicaid/Texas Health Steps and when they are periodically due for their yearly medical checkup in their birthday month.

On request by the client, the Medical Transportation Program (MTP) assists the client with scheduling transportation.

Texas Health Steps medical providers must perform medical checkups on any client who is currently enrolled in Medicaid and who are ages of birth through 20 years of age. Providers also are encouraged to notify the client when he or she is due for the next medical checkup according to the Texas Health Steps Periodicity Schedule.

**Note: Newly enrolled STAR Members must receive a Texas Health Steps medical checkup within 60 days from enrollment.**

The information in this Community First Health Plans manual is an overview that supplements the approved HHSC current year version of the *Texas Medicaid Provider Procedures Manual*, and specifically the Texas Health Steps' *Section*, and Texas Medicaid bi-monthly Bulletins. Providers are to refer to these documents for detailed information about the program.

## **Provider Enrollment**

To enroll in the Texas Health Steps Program, providers must be enrolled in Texas Medicaid and be one of the following:

1. Licensed physicians (MD, DO)
2. Rural Health Clinics (RHCs)
3. Federally Qualified Health Centers (FQHCs)
4. Healthcare providers of facilities (public or private) that can perform the required medical checkup procedures only under the supervision of a physician.
5. Advanced Practice Nurses (APNs) may enroll independently as Texas Health Steps providers if they are recognized by the Texas BON and nationally certified in at least one of the following:
  - a. Family Practice
  - b. Pediatrics
  - c. OB/Gyn
  - d. Adult Health (adults only)
  - e. Women's Health (adolescent females only)
  - f. Certified Nurse Midwives (newborn and adolescent females only)
6. Physician Assistants (PAs) (recommended that a PA have expertise or additional education in the areas of comprehensive pediatric assessment)

Residents may provide medical checkups in a teaching facility under the personal guidance of the attending staff as long as the facility's medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met and the attending Physician has determined the resident to be competent to perform these functions.

A registered nurse (RN) may perform Texas Health Steps checkups only under the supervision of a physician. The physician ensures that the RN has appropriate training and adequate skills for performing the procedures for which they are responsible. Texas Health Steps requires that all RNs performing Texas Health Steps medical checkups complete the online education modules developed by the Texas Health Steps Program. Texas Health Steps online education modules may be accessed at [www.txhealthsteps.com](http://www.txhealthsteps.com). Before a physician delegates a Texas Health Steps checkup to an RN, the physician must establish the RN's competency to perform the services required by the physician's scope of practice. The RN or employer must maintain documentation that the available required courses were completed.

Medicaid providers, except Federally Qualified Health Centers (FQHCs) and/or provider associated with a group, who want to become Texas Health Steps providers, must enroll separately as a Texas Health Steps medical checkup provider. (A Medicaid group must enroll as a Texas Health Steps medical

checkup provider in lieu of each provider within the group enrolling separately). The individual and/or group will be assigned a Texas Health Steps Texas Provider Identifier (TPI) suffix to their Medicaid provider number. For more information, call Texas Medicaid and Healthcare Partnership (TMHP) Customer Service at **800-925-9126 or (512) 514-3000**.

### **How the Texas Health Steps Program Works:**

Texas Health Steps staff, through outreach programs and information, encourages STAR Members to use Texas Health Steps Periodicity Schedule (**Exhibit 10**) when they first become eligible for Medicaid. The components and elements of the Texas Health Steps' checkup and immunizations' visits are based on the American Academy of Pediatrics (AAP) Periodicity Schedule but are modified to meet the State of Texas and Federal regulations. You may find further information in the following publications: *current year Texas Medicaid Provider Procedures Manual*, *Texas Health Steps Section* and Texas Medicaid bi-monthly bulletins.

Community First Health Plan's providers who are enrolled in the Texas Health Steps program must perform medical checkups on any STAR Member who is currently enrolled in Medicaid and who are ages of birth through 20 years of age. Providers are encouraged also to notify the STAR Member when he or she is due for their next checkup according to the Texas Health Steps Periodicity Schedule.

Community First Health Plan's providers may also access Community First Health Plan's secure web portal to access Community First Health Plans STAR Member eligibility. This website contains an indicator as to whether the Member is due or overdue for a Texas Health Steps checkup. An additional indicator identifies if the Member is a child of Migrant Farmworker(s). A provider may obtain access to the web portal by contacting their Community First Health Plans Network Management Representative, requesting a registration form and web portal training.

### **Immunizations Overview**

Clients who are 18 years of age and younger must be immunized according to the Recommended Childhood Immunization Schedule for the United States. If the immunizations are due as part of a Texas Health Steps medical checkup, the medical checkup provider is responsible for the administration of immunizations and may not refer clients to local health departments. **The Department of State Health Services (DSHS) requires that immunizations be administered during the Texas Health Steps medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.**

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult

accompanying a client for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at (512)458-7284. VISs may also be downloaded from the DSHS Immunization Branch's website at [www.immunizetexas.com](http://www.immunizetexas.com).

### **Children of Migrant Farmworkers**

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

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

### **Reimbursement - Medical Checkup**

Community First Health Plans reimburses providers for performing a complete medical checkup and for administration of immunizations at the maximum fee allowed by HHSC. The Texas Health Steps Periodicity Schedule identifies the required procedures that providers must perform during a Texas Health Steps medical checkup based on the age of the child.

### **NOTE: Community First Health Plans Will Not Reimburse Providers for Incomplete Medical Checkups**

If the medical checkup provider identifies a condition that requires follow-up evaluation, diagnosis, and management then:

1. If the provider performing the Texas Health Steps medical checkup is the Community First Health Plans STAR Member's PCP, then the provider may provide treatment of the identified condition. A separate claim for an *established* client office visit may be submitted on the same day as the checkup with an appropriate established client CPT code for the diagnosis and treatment of the identified condition. Every medical checkup will not have a related claim for the evaluation and management of an identified condition. Often minor illnesses and/or conditions (e.g., follow-up of a mild URI) during the Texas Health Steps checkup do not warrant an additional billing for further diagnosis and treatment.
2. If the provider performing the Texas Health Steps checkup is *not* the Community First Health Plans STAR Member's PCP, then the provider



**must** refer the member to their PCP to obtain evaluation and management of any identified conditions.

The Texas Health Steps medical checkup fee includes payment for TB skin tests and collection of blood specimens for all Texas Health Steps required laboratory services included on the medical checkup periodicity schedule. Childhood immunization vaccines and laboratory supplies and testing are available at no cost to Texas Health Steps checkup providers through DSHS. An administration fee is paid for each immunization given during a Texas Health Steps checkup or as part of a follow-up claim, except for services performed in an FQHC or RHC setting. The immunization administration fee is reimbursed at the maximum allowable fee established by HHSC (rates vary based on the number of state-defined components administered for each injection).

### **Newborn Examination**

Providers can bill inpatient newborn examinations with newborn CPT codes 1-99460 and 1-99461 which are considered as Texas Health Steps medical checkups, and include the required medical checkup components as designated on the Texas Health Steps medical checkup periodicity schedule for inpatient newborn infants. This includes a history and physical, with length, height, weight, and head circumference, sensory screening (vision/hearing) Hepatitis B immunization, initial newborn screen at 24-48 hours of age , and health education/anticipatory guidance with the parents or responsible adult (health education by the nursing staff, individually or in a class, is acceptable).

### **Complex Neonate Acuity of Service Matrix**

This matrix serves as a general template to align the level of services that are delivered to Community First Health Plans' newborns that are retained at the hospital past the global period with the level of service that is preauthorized. Medical Director's discretion based on peer-to-peer discussions will be utilized on a case-by-case basis when the clinical status overlaps one or more cells in the matrix. This matrix has been approved by Community First Health Plans' Quality Improvement Committee as the standard criteria to be used for the determination of Revenue Codes/level of services for Community First Health Plans' members.

The authorizations will be driven by the revenue code when pre-authorizing inpatient stays. The level of care is a general description of the category of service that is provided and required. This description may vary between facilities and according to certain contractual mandates. Therefore, level of care will not be used as the “**driver**” for pre-authorization. Please refer to (**Exhibit 8**) for Matrix.

### **Newborn Hearing Screening**

Health and Safety Code, Chapter 47, Vernon's Texas Codes Annotated states that the hearing screening must occur at the birthing facility before the newborn is discharged from the hospital. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with DSHS standards, and notification to the provider, parents, and DSHS of screening results. There is no additional Medicaid reimbursement for the hearing screening as the procedure is part of the newborn DRG. Hospitals should use the current ICD-9-CM procedure code for a hearing examination, not otherwise specified, to report this newborn hearing screen.

This facility-based screening also meets the physician's required components and elements for hearing screening in the inpatient newborn Texas Health Steps checkup. The physician must ensure that hearing screening is completed before discharging the newborn or, when the birthing facility is exempt under the law, there is an appropriate referral for hearing screening to a birthing facility participating in the newborn hearing screening program. The physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to DSHS for tracking and follow-up purposes. If a physician has any concerns about this process, contact the hospital administrator or the DSHS Audiology Services program at (512)458-7724.

If a provider chooses to do a brief examination (not including all of the above components), the provider may bill the new HCPCS code, 1-99431 or 1-99432 with modifier-52, which will not count as a Texas Health Steps checkup.

Community First Health Plans encourages physicians and hospital staff to inform parents of children eligible for Medicaid's Texas Health Steps to schedule an outpatient visit for the next Texas Health Steps medical checkup at one to two weeks of age, and to schedule the regular medical checkups as recommended by the Texas Health Steps Periodicity Schedule.

#### Clients Who Are 4 Through 20 Years of Age - Objective Screening

All clients who are 4, 5, 6, 8, and 10 years of age must be screened for hearing loss with pure tone audiometric threshold screening. **Pure tone audiometric threshold screening must also be performed upon parental request.**

## **Texas Health Steps Medical Checkup Follow-up Visit**

If a component/element of the medical checkup cannot be completed because of a medical contraindication of a Member's condition, then a follow-up visit will be necessary. The Provider must document the reason the component(s) was not completed and schedule a follow-up visit, CPT code 99211. Community First Health Plans reimburses for one follow-up visit, when required, at the maximum allowable fee established by HHSC. For example: redraw of lab specimens, etc.

## **Immunizations**

Providers must immunize children during medical checkups, according to the Recommended Childhood Immunization Schedule for the United States, approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. ***The medical checkup provider is responsible for administration of immunizations (Exhibit 27) and may not refer children to local health departments to receive the immunizations.*** Texas Health Steps encourages medical providers to enroll in the Texas Vaccines for Children Program (TVFC).

For clients not previously immunized, Texas Health Steps medical checkup providers must bring these clients up-to-date on their immunizations, unless medically contraindicated or for reason of conscience, including a religious belief which must be noted on the medical record and billing form.

## **Documentation Requirements**

All Texas Health Steps services require documentation to support the medical necessity of the services rendered including Texas Health Steps medical services. Texas Health Steps services are subject to retrospective review and recoupment if documentation does not support the services billed.

## **Training:**

- Texas Health Steps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in Texas Health Steps.
- These courses may be accessed at [www.txhealthsteps.com](http://www.txhealthsteps.com).
- Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. To obtain free vaccines for clients who are birth through 18 years of age, Texas Health Steps providers must enroll in TVFC at DSHS. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed the current allowable reimbursement.

- To provide Texas Health Steps medical checkups, providers must be enrolled in Texas Medicaid and must be one of the following:
  1. A physician (doctor of medicine [M.D.] and doctor of osteopathy [D.O.]) that is currently licensed in the state where the service is provided.
  2. A rural health clinic (RHCs) or federally qualified health center (FQHC)
  3. A health-care provider or facility (public or private) that is capable of performing the required medical checkup procedures under a physician's direction, such as a regional or local health department, family planning clinic, migrant health clinic, community-based hospital or clinic, maternity clinic, home health agency, or school district. In the case of a clinic, a physician is not required to be present in the clinic at all times during the hours of operation; however, a physician must assume responsibility for the clinic's operation.
  4. An APN who is recognized by the Texas BON and nationally certified to perform in at least one of the following areas of practice:
    5. Pediatrics
    6. Family practice
    7. Adult health (adolescents only)
    8. Women's health (adolescent females only)
    9. Certified nurse midwife (newborns and adolescent females only)
    10. Physician Assistants (PAs)-It is recommended that PAs have expertise or additional education in the areas of comprehensive pediatric assessment.

Texas Health Steps providers should encourage clients to see their primary care provider as their medical home. If the client's primary care provider is not a Texas Health Steps medical provider, the checkup provider must send the primary care provider the records from all Texas Health Steps medical checkups performed for the client. **All primary care providers are encouraged to enroll as Texas Health Steps medical providers.** This allows the client to receive both acute care services and preventive Texas Health Steps services from the same provider.

The following includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the “Y”(yes) referral indicator. If no referral is made, then providers must use the “N” (no) referral indicator.

- A checkup must be submitted with diagnosis code V20.20.
- Procedure Codes Referral Indicator Condition Indicator
- 99381, 99382, 99383, 99384, and 99385 (new client preventive visit) or
- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)
- N: (no referral given)
- NU: (not used)
- 99381, 99382, 99383, 99384, and 99385 (new client preventive visit) or
- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)
- Y: (yes Texas Health Steps or EPSDT referral was given to the client)
- S2: (under treatment) or ST\* (new services requested)
- The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.
- When performed for a Texas Health Steps preventive care medical checkup, procedure codes 99385 and 99395 are restricted to clients who are 18 through 20 years of age.
- Modifier AM, SA, TD, or U7 must be submitted with the Texas Health Steps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.
- Modifier Practitioner
- AM: Physician
- SA: Advance Practicing Nurse rendering service in collaboration with a physician.
- TD : Registered Nurse
- U7: Physician Assistant

Texas Health Steps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter including any immunizations or developmental screening procedures. When submitting claims for Texas Health Steps checkups and services, RHC providers must use the national place-of-service (POS) code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform Texas Health Steps checkups independently of a physician's interactions with the client.

Modifier	Description
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier "-23" to the procedure code of the basic service or by use of the separate 5-digit modifier code 09923.
32	Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "-32" to the basic procedure or the service may be reported by use of the 5-digit modifier code 09932.

**Use procedure code 99211** with the Texas Health Steps provider identifier and Texas Health Steps benefit code when billing for a follow-up visit.

A follow-up visit may be required to complete necessary procedures related to a Texas Health Steps medical checkup or exception-to-periodicity checkup, such as:

- Collection of specimens for laboratory testing that were not obtained during the original Texas Health Steps medical checkup or the original specimen could not be processed.
- Completing sensory or developmental screening that was not completed at the time of the Texas Health Steps medical checkup due to the client's condition.

Required Screening Ages and Recommended Tools		
Screening Ages	Developmental Screening Tools	Autism Screening Tools
9 months	Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS)	
1 year	ASQ or PEDS (if not completed at 9 months or with provider/parental concern)	
18 months	ASQ or PEDS	Modified Checklist for Autism for Toddlers (MCHAT)
24 months	ASQ or PEDS	Modified Checklist for Autism for Toddlers (MCHAT), if not performed at 18 months,
30 months	ASQ or PEDS (if not completed at 24 months or with provider/parental concern)	
3 years	ASQ, Ages and Stages Questionnaire-SE (ASQ-SE), or PEDS	
4 years	ASQ, ASQ-SE, or PEDS	

### **Administrations and Immunizations**

- Providers must not refer clients to the local health department or other entity for immunization administration. Vaccines/toxoids must be obtained from TVFC for clients who are birth through 18 years of age.

### **Texas Health Steps Behavioral Health**

Providers who are PCPs must use the Texas Health Steps Behavioral health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Members must be screened for behavioral health problems, including possible substances abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to Community First Health Plans to include in the Health Passport.

### **DSHS Texas Health Steps Laboratory Services**

Laboratory supplies and laboratory testing are available at no cost to Texas Health Steps providers through the DSHS Laboratory. You may contact the DSHS Laboratory at (512)458-7661, (888)963-7111 ext. 7661 or by fax at (512) 458-7672.

### **Texas Health Steps Medical Checkups Laboratory Procedures**

Providers may not bill the following laboratory services separately or with an office visit or consultation on the same day as a Texas Health Steps visit:

<b>Procedure Code</b>	<b>Description</b>
5-80061 *	Lipid Panel
5-82465 *	Cholesterol serum; total
5-82947 *	Glucose, Quantitative, Blood (except reagent strips)
5-82952 *	Glucose, Tolerance test, each additional beyond three specimens
5-83020	Hemoglobin Electrophoresis
5-83021	Hemoglobin fractionation and quantitation; chromatography
5-83655	Lead
5-83718*	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
5-84478 *	Triglycerides
5-85014	Hematocrit (Hct)
5-85018	Total Hemoglobin (Hgb)

<b>Procedure Code</b>	<b>Description</b>
5-86403	Particle agglutination; screen, each antibody
5-86592	Syphilis; qualitative (e.g., VDRL, RPR, ART)
5-86689	HIV confirmation (Western blot)
5-86701	HIV-1
5-87490	Chlamydia (direct probe)
5-87590	Gonorrhea (direct probe)
5-88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
5-88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
5-88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
5-88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
5-88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
5-88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
5-88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
5-88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
5-88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
5-88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
5-88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
5-88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
5-88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
5-88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
5-88175	Cytopathology, cervical or vaginal (any reporting system), collected



<b>Procedure Code</b>	<b>Description</b>
	in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
* Denotes lab codes that Provider can send to a laboratory of their choice (not required to submit to DSHS laboratory).	

These services and supplies are limited to Texas Health Steps checkup laboratory services provided in a medical checkup to Texas Health Steps Members. Unauthorized use of services and supplies are a violation of federal regulations.

### **Laboratory Supplies**

- The DSHS Laboratory verifies enrollment of Texas Health Steps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides Texas Health Steps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen requisition forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to Texas Health Steps medical providers.
- To obtain a Texas Health Steps (Child Health Laboratory Supplies Order Form), providers can call (512)458-7661 or 1-888-963-7111, ext. 7661, or download the form online at [www.dshs.state.tx.us/lab/MRS\\_forms.shtm](http://www.dshs.state.tx.us/lab/MRS_forms.shtm).

### **Newborn Screening Supplies**

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

Note: For newborn screening, only the specimen collection form (NBS-3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.

To obtain a Newborn Screening Supplies Order Form, medical providers can call (512)458-7661 or 1-888-963-7111, ext. 7661, or download the form online at [www.dshs.state.tx.us/lab/MRS\\_forms.shtm](http://www.dshs.state.tx.us/lab/MRS_forms.shtm).

Contact information for requesting laboratory supplies:

Container Preparation  
Laboratory Services Section, MC 1947

Department of State Health Services  
PO Box 149347  
Austin, TX 78714-93471

(512)458-7661 or 1-888-963-7111, Ext. 7661  
Fax: (512)458-7672

### **Laboratory Submission**

- All required laboratory testing for Texas Health Steps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:
- Specimens collected for Type 2 diabetes, hyperlipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider's choice or to the DSHS Laboratory in Austin if submission requirements can be met.
- Specimens for cervical cancer, gonorrhea, and chlamydia screening are processed by the Women's Health Laboratories (WHL) in San Antonio, TX. Information regarding collection, handling, and submission of these specimens is available from the WHL.
- Providers must send all Texas Health Steps newborn screens to the Texas Department of State Health Services (DSHS), formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Providers must include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.
- Texas Health Steps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Request Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client's name and Medicaid number as they appear on the Texas Benefits Medicaid Card. If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form 1027-A] as eligible for Medicaid), providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory specimen submission form.
- Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word "pending" written on the accompanying specimen submission form will be analyzed, and the provider will be billed.
- Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: [www.dshs.state.tx.us/lab/MRS\\_specimens.shtm](http://www.dshs.state.tx.us/lab/MRS_specimens.shtm).

Note: If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are

identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.

The Texas Health Steps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

DSHS Laboratory Services Section  
Walter Douglass  
PO Box 149163  
Austin, TX 78714-9803  
(512)458-7318 or (888)963-7111 Ext. 7318  
Fax: (512)458-7294

Texas Health Steps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section, MC-1947  
1100 West 49th Street  
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to:

Texas Department of State Health Services  
Laboratory Services Section  
PO Box 149341  
Austin, TX 78714-9341

Or

**Providers may order supplies for Pap smears from:**

Women's Health Laboratories 1100 West 49th Street  
Austin, TX 78756-3199  
Phone: (512)776-7318

Use order Form AG-30 or 1643 or letterhead stationery, and include your Texas Health Steps provider number.

**Internet Search:**

"DSHS Texas Health Steps Forms" then Click on: "[Child Health Record Forms](#)"

The Texas Health and Human Services Commission are introducing a new system that uses digital technology to streamline the process of verifying a person's Medicaid

eligibility and accessing their Medicaid health history. The two main elements of the system are:

- The Texas Benefits Medicaid Card,
- An online website is available where Medicaid providers can get up-to-date information on a patient's eligibility and history of services and treatments paid by Medicaid.

**What information is on the Texas Benefits Medicaid Card?**

- The design of the new card conforms to the standards of the Workgroup for Electronic Data Interchange (WEDI). It is designed to show the same type of information shown on private health insurance cards.
- The front of the card has:
  - ✓ Client name and Medicaid ID number (patient control number – PCN)
  - ✓ Managed care program name, if applicable (STAR, STAR Health, STAR+PLUS)
  - ✓ Date the card was issued
  - ✓ Billing information for pharmacies
- Pharmacy and physician information for those in the Medicaid Limited program
- The back of the card has:
  - ✓ A statewide toll-free number that clients can call if they need help or questions about using the card. A website address.

## **Benefits and Limitations**

Community First Health Plans covers medical checkup services for persons who are ages of birth through 20 years of age and when delivered according to the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the STAR Member's life and identifies the period, based on the STAR Member's age when medical checkup services are reimbursable.

The STAR Member's age on the first day of the month determines the STAR Member's eligibility for a medical checkup. If a STAR Member has a birthday on any day, except the first day during the month, the new eligibility period begins on the first of the following month. When a STAR Member turns 21 years old during a month, the STAR Member continues to be eligible for Texas Health Steps services through the end of their birthday month.

Providers are responsible for documenting in office records that the previous year's medical checkup was completed. This documentation can be based on the STAR Member's previous medical record or verbal information given by the STAR Member or responsible adult.

**Benefits:** Providers are to check the STAR Member's Texas Benefits Medicaid Card to determine periodic eligibility. A "message" under the STAR Member's name indicates the Texas Health Steps service for which the STAR Member is currently eligible. A checkup provided when a Texas Health Steps statement does not show that a medical checkup is due, is considered an Exception-to- Periodicity Schedule.

An alternate verification process allowed by Community First Health Plans is our secure provider web portal. Member eligibility may be verified on the date of service using this website. Provider must make a screen print of the member eligibility record on the date that services are rendered by the Provider and retain this copy. If a Provider does not have a login to access Community First's provider web portal, contact your Community First Health Plans' Network Management Provider Representative.

## **Billing Information for Texas Health Steps**

Providers should bill their usual and customary fees. Community First Health Plans will reimburse providers the lesser of the billed amount or the maximum allowable fee set forth by HHSC. Electronic claims are accepted by Availity and should be transmitted through Availity using Community First Health Plans' Payor Identification.

Availity Payor ID: COMMF  
Availity Receiver Type: F

Providers must be certain that all information is accurate:

## **For Electronic Submission:**

- The Billing and Rendering Provider's NPI and taxonomy code (which have been attested with the State) are included. (A group NPI and taxonomy code may be included in lieu of the Rendering/Performing Provider's NPI/taxonomy code if the group has attested as a "Texas Health Steps Clinic/Provider".)
- The diagnosis code will always be V20.20
- Type of service will always be "S."
- Place of service will always be "1" or alpha "O."
- Place of service on the UB-04 (locator 44) is auto plugged based on the type of bill indicated on the claim.

The STAR Member's record must reflect that each of the required screening procedures, based on the STAR Member's age, was completed in accordance with the medical checkup periodicity schedule.

#### **For Paper Submission:**

- The Provider's NPI (CMS-1500 (block 24-J) is included. Provider must have attested a TPI with the NPI submitted on the claim. (A group NPI may be included in lieu of the Rendering/Performing Provider's NPI if the group has attested as a "Texas Health Steps Clinic/Provider".)
- The diagnosis code on the CMS-1500 (block 21.1), and on the UB-04 (locator 67) will always be V20.20
- Type of service on the CMS-1500 (block 24C), and on the UB-04 (locator 44) will always be "S."
- Place of service on the CMS-1500 (block 24B) will always be "1" or alpha "O."
- Place of service on the UB-04 (locator 44) is auto plugged based on the type of bill indicated on the claim.

The STAR Member's record must reflect that each of the required screening procedures, based on the STAR Member's age, was completed in accordance with the medical checkup periodicity schedule.

#### **Texas Health Steps Medical Checkup Code Modifiers**

When using a CMS-1500 for billing Texas Health Steps services, the place-of-service will always be "1" Or alpha "O." Providers who use a UB-04 claim form for billing Texas Health Steps services will use the "appropriate type of bill" in block 4 of the form. Record the following provider type modifier codes in block 24 of the CMS-1500 and block 44 of the UB-04 claim form to identify who performed the physical examination of the medical checkup.

#### **Texas Health Steps Medical Checkup Procedure Codes**

Providers must record the following procedure codes on the CMS-1500 or UB-04 claim form to receive reimbursement for a medical screen:

- Appropriate Texas Health Steps medical checkup or follow-up visit code with appropriate modifier designating type of provider that rendered unclothed physical, and/or exception to periodicity modifier, if applicable.
- Appropriate Immunization administration code(s) with appropriate modifiers designating state-defined components, if applicable. One initial administration code must be submitted for the first vaccine. Additional administration code(s) must be submitted if more than 1 vaccine is administered.
- Immunization code(s) administered.
- CPT code for TB skin test code (one year through 20 years old), if administered.

#### **Texas Health Steps Medical Checkup Procedure Codes:**

<b>Procedure Code</b>	<b>Description</b>
S-99381	Initial comprehensive preventive medicine E & M of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age younger than 1 year old).
S-99382	Early childhood (Age 1 through 4 years old)
S-99383	Late childhood (Age 5 through 11 years old))
S-99384	Adolescent (Age 12 through 17 years old))
S-99385	18 – 39 years (restricted to age 18 through 20 years old) <b>or</b>
S-99391	Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age younger than 1 year old).
S-99392	Early childhood (Age 1 through 4 years old)
S-99393	Late childhood (Age 5 through 11 years old)
S-99394	Adolescent (Age 12 through 17 years old)
S-99395	18 – 39 years (restricted to age 18 through 20 years old)

#### **Exception to Periodicity Modifiers:**

Use with medical screen codes 99381-99385 or 99391-99395 to indicate the reason for an Exception-to-Periodicity.	
23	Unusual Anesthesia
32	Mandated Services
SC	Medically Necessary Service or supply

One of the following modifiers must be used to indicate the practitioner who performed the unclothed physical examination on the medical screen. An FQHC provider must bill at Texas Health Steps visits with modifier EP, service provided as part of Medicaid and Early Periodic Screening Diagnosis and Treatment (EPSDT), in addition to one of the following:

<b>Modifier</b>	<b>Description</b>
AM	Physician, Team member service
SA	Nurse Practitioner rendering service in collaboration with a physician
TD	RN
U7	Physician's Assistant services for other than assistant at surgery

### **Texas Health Steps-Comprehensive Care Program (CCP)**

If children who are ages of birth through 20 years of age have abnormal results on the Texas Health Steps checkups, screenings, or laboratory tests, the Texas Medicaid Program also provides funds for appropriate follow-up care. Physicians who provide Texas Health Steps checkups may be able to diagnose and treat the finding in their office. For the Medicaid fee-for-service program, see the Texas Medicaid Provider Procedures Manual for information about coding and billing for these services. When abnormal findings require referral for diagnosis and treatment by specialty providers, the physician may be able to do that directly or need to get prior approval from HHSC or its designee, TMHP. For services covered under the traditional Medicaid program, instructions are in the Texas Medicaid Provider Procedures Manual.

For those services covered under Texas Health Steps-CCP, the primary or specialty providers must contact TMHP for prior approval. For example, Texas Health Steps-CCP covers private duty nursing, customized durable medical equipment, therapies, and inpatient and outpatient psychiatric services beyond traditional Medicaid benefits, nutrition counseling, and unlimited pharmaceuticals. These services require documentation of medical necessity and prior approval.

The Texas Medicaid Program continually reviews current policies and requests for coverage of new health and health-related services. When Medicaid policies are revised or adopted, information and implementation instructions are published in the bimonthly Texas Medicaid Bulletin.

For Medicaid-eligible children enrolled in a Medicaid Managed Care Organization (MCO), all the same benefits must be provided as described in the Texas Medicaid Provider Procedures Manual. Reimbursement and precertification requirements are negotiated through contracts and other



agreements between the State of Texas or one of its contracting MCO's and the providers. Providers are referred to the appropriate provider manuals of the Medicaid MCO's. Providers may contact DSHS, either through the program offices in Austin or the regional offices. Refer to: "Communication Directory" on page 85 for contact information. For information on Texas Health Steps-CCP services please contact Community First Health Plans' Health Services Department at **(210) 358-6050**, or 800-434-2347.

## **B. Medicaid Managed Care Covered Service**

Community First Health Plans STAR Members are entitled to all covered services in the Texas Medicaid Program. PCPs shall provide and arrange for the provision of all covered services.

Note: STAR Members do not have to pay a co-payment for covered medical services.

Community First Health Plans is responsible for authorizing, arranging, coordinating and providing Covered Services in accordance with the requirements of the STAR Benefit Program as outlined in its agreement with HHSC. Community First Health Plans must provide Medically Necessary Covered Services to all enrolled Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. Community First Health Plans may not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member. Community First Health Plans will provide full coverage for Medically Necessary Covered Services to all Members without regards to the Member's:

- Previous coverage, if any, or the reason for termination of such coverage;
- Health status;
- Confinement in a health care facility; or
- For any other reason.

Community First Health Plans must provide Covered Services as described in the most recent *Texas Medicaid Provider Procedures Manual*, the Texas Health Steps Manual (a supplement to the Provider Procedures Manual), and in all Texas Medicaid Bulletins, which update the Provider Procedures Manual except for those services identified as non-capitated services. Covered Services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

### **The following is a list of Covered Services:**

- Ambulance services

- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Screening
  - Inpatient hospitalization (free standing hospital and general acute-care hospital and TCADA licensed facilities.)
  - Treatment by psychiatrists, psychologists, LPCs, LCSW-ACPs, LMFTs, and LCDCs
  - Chemical dependency outpatient counseling
  - Outpatient Behavioral Health counseling services are available for all STAR members.
- Birthing center services if available within the service area
- Case Management for Children and Pregnant Women (CPW)
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

### **Durable Medical Equipment and Other Products Normally Found in a Pharmacy**

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

Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and Community First Health Plans' Provider Manual for information regarding the scope of coverage of durable medical equipment and other products commonly found in a pharmacy. Community First Health Plans encourages your pharmacy's participation in providing these items to Medicaid clients.

Call Community First Health Plans Member Services at (210) 358-6060 or (800)434-2347 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must submit a claim for reimbursement:

### **Paper Claims**

Community First Health Plans Health Plans, Inc.  
P. O. Box 853927  
Richardson TX 75085-3927

or

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

### **Electronic Claims**

Community First Health Plans accepts electronically submitted claims through Availity. Claims filed electronically must be files using the 837P or 837I format. Billing instructions can be found at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First Health Plans' Payor Identification as indicated below:

Payor ID: COMMF  
Receiver Type: F

### **Cancellation of Product Orders:**

A provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Member or the Member's authorized representative submits an oral or written request. The provider must maintain records documenting the request.

Call 800-434-2347 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

### **Emergency Dental Services**

Community First Health Plans is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. Community First Health Plans will pay for devices for craniofacial anomalies, 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 abscesses of tooth or gum origin.

### **Non-Emergency Dental Services**

Medicaid Non-emergency Dental Services:

Community First Health Plans is not responsible for paying for routine dental services provided to Medicaid 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, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

### **Intermediate Oral Evaluation with Fluoride Varnish Application**

An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients who are 6 through 35 months of age.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup visit and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202.

An intermediate oral evaluation with fluoride varnish application is limited to Texas Health Steps medical checkup providers who have completed the required benefit education and are certified by DSHS Oral Health Program to perform an intermediate oral evaluation with application of fluoride varnish. Training for certification is available as a free continuing education course on the Texas Health Steps website at [www.txhealthsteps.com](http://www.txhealthsteps.com). The intermediate oral evaluation with fluoride varnish application add-on includes the following components:

- Intermediate oral evaluation
- Fluoride varnish application
- Dental anticipatory guidance to include:

- The need for thorough daily oral hygiene practices
- Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
- Texas Health Steps eligibility qualifies the client for dental services
- Diet, nutrition, and food choices
- Fluoride needs
- Injury prevention
- Antimicrobials, medications, and oral health

**C. Coordination with Non-Medicaid Managed Care Covered Services (Non-Capitated Services)**

Community First Health Plans will make a good faith effort to coordinate services for Non-Medicaid Managed Care Covered Services by sub-contracting for these services as appropriate, entering into Memorandums of Understanding (MOU) or direct contracts with providers/agencies that provide these services. PCP will be responsible for the appropriate coordination and referral of Members for these services. Community First Health Plans is not responsible for the payment of dental services.

Medicaid dental services are described under Title 25 Texas Administrative Code (TAC) Chapter 33 Subchapter G, (25 TAC 33) and at the Secretary of State's Web site, [www.sos.state.tx.us](http://www.sos.state.tx.us).

**Dental Services:** Dental services for STAR members are covered from birth through the age of 20 years under the Texas Health Steps. Children should have their first dental checkup at 6 months of age and every 6 months thereafter. Services include all medically necessary dental treatment (ex: exams, cleanings, x-rays, fluoride treatment, and restorative treatment). Children under the age of 6 months can receive dental services on an emergency basis. Members may contact:

- DentaQuest 800-516-0165
- MCNA Dental 800-494-6262

**D. Texas Agency Administered Programs and Case Management Services**

**Pharmacy Program**

Community First covers prescription medications. Community First Members can get their prescriptions 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](mailto:contact@hhsc.state.tx.us)

### **Over The Counter Drugs**

Community First 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](http://www.cfhp.com)

### **General Guidelines**

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

Medicaid STAR members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of the 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 Health Solutions* processes Texas Medicaid pharmacy prior authorization for Community First 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 Navitus Health Solutions Website, ePocrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization (PA) forms online via [www.navitus.com](http://www.navitus.com) under the “Providers” section or have them faxed by Customer Care to the Prescribers 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 877-908-6023 and speak with the Prior Authorization department between 8:00 a.m. and 5:00 pm Monday through Friday Central Time Zone to submit a PA request over the phone. After hours, Providers will have the option to leave 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*. 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 dispensing 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 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.

In addition if prior authorization for a medication is not immediately available, a 72-hour emergency supply may be dispensed when the pharmacist on duty recommends it as clinically appropriate and when the medication is needed without delay. Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual and/or Community First Health Plan's Medicaid Provider Manual for information regarding reimbursement for 72-hour emergency supplies of prescription claims. It is important that pharmacies understand the 72-hour emergency supply policy and procedure to assist Medicaid clients.

Pharmacy prior authorization requests should be faxed to (210) 358-6381. 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 an on-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.

## **E. Essential Public Health Services**

Community First Health Plans works with the Health and Human Services Commission (HHSC) through a Memorandum of Understanding (MOU) to

provide essential public health services. Community First Health Plans makes a good faith effort to enter into a subcontract for Covered Services with Essential Public Health Entities in support of its mission to diagnosis and investigate diseases, health problems and threats to the public's health. Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

- Sexually Transmitted Diseases (STDs) services;
- Confidential HIV testing;
- Immunizations;
- Tuberculosis (TB) care;
- Family Planning services;
- Texas Health Steps medical checkups, and
- Prenatal services

### **School Health and Related Services (SHARS)**

School Health and Related Services (SHARS) is a Medicaid service and is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts or shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services included in the student's Individualized Education Program (IEP). Using existing state and local special education allocations as the state match, SHARS providers are reimbursed the federal share of the payment when services are provided to students who meet all of the following requirements:

- Medicaid eligible and under 21 years of age
- Meet eligibility requirements for special education described in the Individuals with Disabilities Education Act (IDEA)
- Have IEPs that prescribe the needed services.

Current SHARS services include:

- Assessment
- Audiology
- Counseling
- School Health Services
- Medical Services
- Occupational, Physical and Speech Therapy
- Psychological Services
- Special Transportation

These services must be provided by qualified professionals under contract or employed by the school district/shared services arrangements. Furthermore,

the school district/shared services arrangements must be enrolled as a SHARS Medicaid provider in order to bill Medicaid for these services.

### **Early Childhood Intervention**

Community First Health Plans coordinates and cooperates with the Early Childhood Intervention (ECI) programs. ECI serves children under the age of three who have disabilities or developmental delays. ECI teaches families how to help their children reach their potential through education and therapy services.

The Provider 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 established in the IFSP. If the family or a provider identifies a child under the age of three to be at risk for having disabilities and/or developmental delays, they must refer the STAR Member to ECI within two working days.

The provider does not have to give a diagnosis to refer the STAR Member for ECI services. ECI will conduct developmental screenings, assess the child for developmental delay, and determine if the STAR Member is eligible to receive ECI services. Developmental delays are defined as any significant delays in any of the following areas:

- ✓ Cognitive
- ✓ Language or speech
- ✓ Self-help skills
- ✓ Gross or fine motor skills
- ✓ Social or emotional

Once the child is enrolled, a plan will be developed to outline the services for the child. ECI provides services at the child's home and in a community setting. If the child is not eligible for ECI, the staff will refer the family to other resources.

ECI services could include:

- ✓ Assistive Technology
- ✓ Audiology
- ✓ Early Identification, Screening & Assessment
- ✓ Family Counseling
- ✓ Family Education
- ✓ Home Visits

- ✓ Health
- ✓ Medical (diagnostic or evaluation services only)
- ✓ Nursing
- ✓ Nutrition
- ✓ Occupational Therapy
- ✓ Physical Therapy
- ✓ Psychological
- ✓ Service Coordination
- ✓ Social Work
- ✓ Speech Instruction
- ✓ Speech-Language Pathology
- ✓ Transportation
- ✓ Vision

Primary referral sources include:

- ✓ Hospitals, Including Prenatal and Postnatal Care Facilities;
- ✓ Physicians
- ✓ Parents
- ✓ Day Care Programs;
- ✓ Local Educational Agencies;
- ✓ Public Health Facilities;
- ✓ Other Social Service Agencies; or
- ✓ Other Health Care Providers.

To refer a STAR Member to an ECI program, providers can call the ECI Care Line at **800-628-5115**.

**Note:** Community First Health Plans does not require contracted providers to obtain preauthorization for ECI services. Community First Health Plans does require a copy of the current ECI Individual Family Service Plan (IFSP) as well as a copy of the transition plan which is created in advance of the child aging out of ECI eligibility. These documents allow CHFP to ensure that the ongoing needs of the child are addressed and to facilitate continuity of care.

### **Mental Health Targeted Case Management**

Community First Health Plans working with the Member's PCP through the Local Mental Health will assess the Member's eligibility for rehabilitative and targeted DSHS case management. The Texas Medicaid Program provides the following service coordination and case management services:

- Service coordination for people with mental retardation or related condition (Adult or Child) per consumer, per month
- Case Management for people with serious emotional disturbance (Child, 3–17 years of age)

- Case Management for people with severe and persistent mental illness (Adult, 18 years of age and older) Service
- Individual Community Support Services Service Coordination for people with mental retardation or related condition (Adult or Child) G9012 Once per calendar month Routine Case Management (Adult) T1017 TF 32 units (8 hours) per calendar day for people 18 years of age or older.

A MR service coordination reimbursable *contact* is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual eligible for service coordination. To bill and be paid for one unit of service coordination per month, at least one face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

A MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Service coordination and case management services are not reimbursable when provided to a client eligible for Medicaid and receiving services through the Home and Community-Based Services (HCS) waiver. These services are included in the waiver. Claims submitted to TMHP for people receiving services under the HCS waiver are identified quarterly by DADS and payments are recouped.

The Texas Medicaid Program must *not* be billed for service coordination or case management services provided to people who are residents or inpatients of:

- Nursing facilities (for people not mandated by the Omnibus Budget Reconciliation Act [OBRA] of 1987)\*
- Intermediate care facilities for mental retardation\*
- State mental retardation facilities\*
- State mental health facilities
- Title XIX participating hospitals including general medical hospitals
- Private psychiatric hospitals
- Medicaid-certified residence not already specified
- Institutions for mental diseases such as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of people with mental diseases including medical attention, nursing care, and related services
- Jail or public institution

\* A contact by the service coordinator to assist in discharge planning from some of the above may be reimbursed if provided within 180 days before discharge. Service coordination services provided to people who are on pre-discharge furlough to the community from a nursing facility, intermediate care facility, or state mental retardation facility may be reimbursed. Service coordination services provided to people who are on trial placement from a state mental retardation facility to the community may be reimbursed if the person remains eligible for Medicaid upon release from the facility and receives regular Medicaid coverage.

The Texas Medicaid Program must *not* be billed for MH case management services provided before the establishment of a diagnosis of mental illness and authorization of services.

### Individual Community Support Services

Service	Proc Code	Modifier	Limitation
Service Coordination for people with mental retardation or related condition (Adult or Child)	G9012		Once per calendar month
Routine Case Management (Adult)	T1017	TF	32 units (8 hours) per calendar day for people 18 years of age or older
Routine Case Management (Child & Adolescent)	T1017	TF and HA	32 units (8 hours) per calendar day for people less than 18 years of age
Intensive Case Management (Child & Adolescent)	T1017	TG and HA	32 units (8 hours) per calendar day for people less than 18 years of age.

### Mental Health Rehabilitation

Service	Proc Code	Modifier	Limitations
Day Program for Acute Needs	G0177		6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Day Program for Acute Needs, ACT or ACT alternative consumer	G0177	HK	6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Rehabilitative Counseling and Psychotherapy, individual	H0004		A minimum of 3 units (45 continuous minutes) to a maximum of 16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Rehabilitative Counseling and Psychotherapy, group	H0004	HQ	A minimum of 3 units (45 continuous minutes) to a maximum of 16 units (4 hours) per calendar day, in any combination, for people 21 years of age or older
Medication Training and Support, Adult Individual	H0034		8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Adult, ACT or ACT alternative consumer, individual	H0034	HK	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older

Medication Training and Support, Adult, group	H0034	HQ	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Adult, ACT or ACT alternative consumer, group	H0034	HK and HQ	8 units (2 hours) per calendar day, in any combination, for people 18 years of age or older
Medication Training and Support, Child & Adolescent, individual	H0034	HA	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Medication Training and Support, Child & Adolescent, with other, individual	H0034	HA and HQ	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Medication Training and Support, Child & Adolescent, with other, group	H0034	HA, HQ, HR or UK	8 units (2 hours) per calendar day, in any combination, for people less than 18 years of age
Crisis Intervention Services, Adult	H2011		96 units (24 hours) per calendar day, in any combination
Crisis Intervention Services, Adult, ACT or ACT alternative consumer	H2011	HK	96 units (24 hours) per calendar day, in any combination

Service	Proc Code	Modifier	Limitations
Crisis Intervention Services, Child & Adolescent	H2011	HA	96 units (24 hours) per calendar day, in any combination
Skills Training and Development, Adult, Individual	H2014		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Adult, group	H2014	HQ	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Child & Adolescent, individual	H2014	HA	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills Training and Development, Child & Adolescent, with other, individual	H2014	HA and HR or UK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, individual	H2017		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older



Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, individual	H2017	HK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, by RN, individual	H2017	TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services ACT or ACT alternative consumer, by RN, individual	H2017	HK and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, group	H2017	HQ	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, group	H2017	HQ and HK	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, by RN, group	H2017	HQ and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, by RN, group	H2017	HQ and HK and TD	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial Rehabilitative Services, Individual, Crisis	H2017	ET	96 units (24 hours) per calendar day, in any combination
Psychosocial Rehabilitative Services, ACT or ACT alternative consumer, individual, crisis	H2017	HK and ET	16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older

### Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) is a case management program that provides health related case management services to eligible children and pregnant women.

***Eligibility for CPW:*** Any Medicaid eligible pregnant woman (of any age) or child (birth through age 20) with a health condition or health risk is eligible for the CPW program. Health condition or health risk is defined as a medical condition, illness, injury or disability that results in limitation of function, activities or social roles in comparison with same age peers in the general

areas of physical, cognitive, emotional or social growth and development. There must also be a need for services to prevent illness(es) or medical condition(s), to maintain function or to slow further deterioration of the condition and desire health related case management services or a pregnant woman with a high-risk condition during pregnancy.

CPW case managers must provide services directly with the client or with the parent/legal guardian if the client is under the age of 18. Requests for CPW services may be initiated by the provider, the member or a family member.

CPW case managers submit requests to the Department of State Health Services for determination of eligibility for case management services. Licensed social workers and registered nurses provide CPW services.

To make a referral, call the Texas Health Steps Outreach and informing line 1-877-THSTEPS (847-8377) or call a CPW case management provider in your area. A list of CPW providers can be found on the DSHS Case Management Website, <http://www.dshs.state.tx.us/caseman/HSR8.shtm>

Additional information on the CPW program can be found at <http://www.dshs.state.tx.us/caseman/default.shtm>

## **Texas Health Steps Medical Case Management**

### **Department of Assistive and Rehabilitative Services (DARS) - Blind Children's Vocational Discovery and Development Program**

#### **Texas Health Steps Case Management:**

Texas Health Steps Case management services are provided to help Community First Health Plans Medicaid Members get necessary medical, social, educational, and other services; encourage cost-effective health and health-related care; discourage overutilization or duplication of services; and make appropriate referrals to specialty providers. Community First Health Plans' Case managers assess a client's need for medical, social, educational, and other services and then develop a service plan to address those needs.

#### **Texas Commission for the Blind Case Management:**

##### Service Description:

This is a rehabilitation agency that assists persons with a visual impairment with finding & maintaining a job. They offer case management, counseling, referrals, physical & mental restoration, visual aids & mobility programs.

Toll Free: 800-252-5204; 800-687-7014

Hours: 8:00 am - 5:00 pm, Monday - Friday

Eligibility: Persons with visual impairments

Fee Structure Details: None

Resource Categories:

Employment and Financial Assistance

Mobility and Transportation

Communication

Assistive Technology

Psychological and Counseling Services Post-secondary Education Services

The Division for Blind Services Blind Children's Vocational Discovery and Development Program (BCVDDP) helps Texas families by providing information and support to help their children grow and thrive. A Blind Children's Program Specialist—an expert in providing services to children with visual impairments—works with each child and family to create a Family Service Plan. The plan—tailored to the child's unique needs and circumstances—is a flexible document that will develop along with the child.

**Who is eligible?**

Children between the ages of birth and 22 years who live in Texas and have vision impairment are eligible for services.

**What services are available from the Children's Program?**

BCVDDP offers a wide range of services that are tailored to each child and family's needs and circumstances. We can:

- Assist child in developing the confidence and competence needed to be an active part of their community
- Provide support and training to parent in understanding your rights and responsibilities throughout the educational process
- Assist parent and child in the vocational discovery and development process
- A. Provide training in areas like food preparation, money management, recreational activities and grooming
- Supply information to families about additional resources.

By working directly with your entire family, this program can help the child develop the concepts and skills needed to realize their full potential.

**Where can Members apply for services or get more information?**

For information on any Division for Blind Services program or to apply for services, contact any DBS office located throughout Texas. To find the nearest office, check the [DBS Offices in Your Area](#) feature on this web site or call the Division for Blind Services at 800-628-5115.

### **Tuberculosis Services Provided by DSHS-approved providers**

- Community First Health Plans providers must report all confirmed or suspected cases of TB for a contact investigation and directly observed therapy (DOT) to Local Tuberculosis Control Health Authority (LTCHA) within one (1) working day of identification, using the procedures and forms (**Exhibit 9**) for reporting TB adopted by DSHS.
- Community First Health Plans providers must coordinate with LTCHA and report any Community First Health Plans Health Plans STAR Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

### **Communicable / Infectious Diseases**

- Community First Health Plans providers must report all conditions on the Infectious Disease Report (**Exhibit 28**) as indicated as when to report each condition. Suspected cases of illness considered to be **public health emergencies, outbreaks, exotic diseases**, and unusual group expressions of disease must be reported to the local health department or DSHS **immediately**. Other diseases for which there must be a quick public health response must be reported **within one working day**. All other conditions must be reported to the local health department or DSHS **within one week**.
- Community First Health Plans providers must report notifiable conditions,) or other illnesses that may be of public health significance, directly to the local or health service regions by using Infectious Disease Report (Exhibit 28). Paper reporting forms can be obtained by calling your local or health service region. As a last resort or in case of emergency, reports can be made by telephone to the state office at 800-252-8239 or (512)458-7111. Calling (512)458-7111 after hours will reach the physician/epidemiologist-on-call.

### **Lead Screening Program**

- Community First Health Plans providers must follow the blood lead screening and testing guidelines for Texas Children (**Exhibit 29**). Community First Health Plans providers must report all cases with an elevated blood level of 10 mcg/dL or greater to:

Texas Childhood Lead Poisoning Prevention Program  
Epidemiology & Disease Surveillance Unit  
Texas Department of State Health Services  
PO BOX 149347  
Austin, Texas 78714-9347  
800-588-1248  
[www.dshs.state.tx.us/lead](http://www.dshs.state.tx.us/lead)

## **Medical Transportation Program through Texas Department of Health and Human Services (HHSC)**

STAR Members and their attendants (attending physicians must specify attendants) are eligible to receive transportation service through the Medical Transportation Program (MTP). This program is sponsored by the Texas Department of Health and Human Services (HHSC).

MTP will ensure that STAR Members have non-emergency transportation to and from providers/facilities. MTP is available to STAR Members when they have no other means of transportation, and are receiving covered Medicaid services.

To help with the arrangement of transportation services for a Community First Health Plans STAR Member, the recipient or an advocate, such as a case manager, social worker, or medical-provider staffer, simply calls the MTP toll-free number, **1-877-633-8747** between 8:00 a.m. and 5:00 p.m. CST (including the noon hour, Monday through Friday, except federal holidays) and asks for assistance. The intake specialist will ask for the recipient's Medicaid number; the medical provider's name, addresses, and phone; the date and time of the health-care appointment; and the health-care service being provided. Please contact MTP at **(210) 949-2020** or **877-633-8747 (outside San Antonio)**. Community First Health Plans' Member Services Department is also available to assist STAR Members with transportation services.

Community First Health Plans will cover ambulance transportation under the following circumstances:

**Emergency:** When the condition of the STAR Member is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is an emergency service and does not require preauthorization.

**Non-Emergency:** Any ambulance services ground or air not considered an emergency (see above) must be preauthorized by Community First Health Plans prior to rendering transportation services.

## **WIC — Women, Infants and Children Program**

WIC is a nutrition program that helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy. Nutrition education and counseling, nutritious foods, and help accessing health care are provided to low-income women, infants, and children through the Special Supplemental Nutrition Program, popularly known as WIC.

Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.

### **Eligibility Requirements**

- **Meet the income guidelines.** Households with incomes at or below 185 percent of the federal poverty income level are eligible. WIC determines income based on gross income. WIC counts all of the members of a household, related or unrelated. WIC counts an unborn baby as a household member. Click to view [Income Eligibility Guidelines \(114K, PDF\) viewing information](#).
- **Be at nutritional risk.** WIC clients receive an initial health and diet screening at a WIC clinic to determine nutritional risk. WIC uses two main categories of nutritional risk: (1) medically-based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and (2) diet-based risks such as poor eating habits that can lead to poor nutritional and health status. Clients will be counseled at WIC about these risks and the outcome influenced by nutrition education and nutritious foods provided by WIC.
- **Live in Texas.** WIC clients usually receive services in the county where they live. U.S. citizenship is not a requirement for eligibility.
- Clients must apply **in person** except in certain limited cases.

All WIC services are free to those who are eligible.

WIC provides benefits each month which are taken to grocery stores and used to buy nutritious foods. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C-rich fruit and vegetable juice, milk, eggs, cheese, beans, and peanut butter. Different food packages are issued to different clients. For example, mothers who are totally breastfeeding their babies without formula are issued tuna and carrots in addition to other foods.

Clients receive encouragement and instruction in breastfeeding. In many cases, breastfeeding women are provided breast pumps free of charge. WIC helps clients learn why breastfeeding is the best start for their baby, how to breastfeed while still working,

For information on how to apply for WIC Call (toll free): **1 800-942-3678**

### **DADS Hospice Services**

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services unrelated to the treatment of the client's terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued a Texas Benefits Medicaid Card with "HOSPICE" printed on it. Clients may cancel their election at any time.

DADS pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

For DADS Hospice billing questions, call 1-512-490-4666.

When the services are unrelated to the terminal illness, Medicaid (TMHP) pays its providers directly. For questions about hospice billing, call TMHP at 800-626-4117. Providers are required to follow Medicaid guidelines for prior authorization when filing claims to TMHP for hospice clients. Fax authorization requests to 1-512-514-4209.

Nonhospice providers may be reimbursed directly by TMHP for services rendered to a Medicaid hospice client.

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership

PO Box 200105  
Austin, TX 78720-0105

You can request a formal appeal by filing a written request for a hearing so that Department of Aging and Disability Services (DADS) receives it within 15 days after you receive DADS' official notice of action. The request must be addressed to:

Fairy Rutland, Hearings Department  
Health and Human Services Commission  
P.O. Box 149030  
Mail Code W-613  
Austin, Texas 78714-9030

The request for the hearing may be in the form of a petition or letter. It must state the reason for appeal. You must be notified in writing at least 20 days before the date of the formal appeal hearing, or, if the hearing is expedited, 10 days before the formal appeal hearing. You may submit written notification to HHSC of withdrawal of the hearing request any time before conclusion of the formal appeal hearing.

### **Texas Vaccines for Children Program**

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 individuals birth through 18 years of age.

Qualified Medicaid Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page: [www.dshs.state.tx.us/immunize/tvfc/default.shtm](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 the "U1" modifier, which indicates private stock. 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.

## **F. Family Planning Services**

### **Definition**

Family Planning services are preventive health, medical, counseling, and educational services, which help individuals in managing their fertility and achieving optimal reproductive and general health.



If a Member requests contraceptive services or family planning services, the Providers must also provide the Member counseling and education about family planning and available family planning services.

Providers cannot require parental consent for Members who are minors to receive family planning services. Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

## **Rules and Regulations**

The Social Security Act governing TANF mandates offering and promptly providing Family Planning Services to prevent and reduce unplanned and out-of-wedlock births for appropriate adults and youths, including minors who may be considered sexually active.

- Family Planning Members must have freedom of choice in the selection of contraceptive methods, as medically appropriate.
- Family Planning Members must have the freedom to accept or reject services without coercion.
- Family Planning Services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, disability, religion, national origin, or contraceptive preferences.
- Only the STAR Member, not their parents, spouses, or any other individual, may consent to the provision of Family Planning services. However, counseling may be offered to adolescents, which encourages them to discuss Family Planning needs with a parent, an adult family member, or other trusted adult.
- Federal regulations require the safeguarding of a STAR Member's confidential choice of birth control and Family Planning services. Seeking information from third party insurance resources may jeopardize the STAR Member's confidentiality; therefore, prior insurance billing is not a requirement for billing Family Planning.

## **Access to Services**

STAR Members may select any Texas Medicaid Provider to perform their Family Planning services. The provider's participation with Community First Health Plans is not mandatory.

## **Family Planning Visits**

A Family Planning annual visit is allowed once per year (per State's fiscal year: September 1 through August 31), per provider. If a provider inadvertently bills a second annual exam, the procedure code will be automatically changed to **99213**, and reimbursed at the lesser of the current Medicaid fee schedule or the contracted rate.

### **Specific Family Planning Procedure Codes and Definitions**

To be reimbursed for an annual visit, the provider must perform a comprehensive health history and physical examination, provide indicated laboratory evaluations, assess the STAR Member's problems and needs, and set up an appropriate management plan. The history and physical examination must include the following:

#### **Female Members:**

##### **Health History:**

- Gynecologic history including sexual history and STD/HIV risk
- Menstrual history
- Contraceptive history
- Obstetric history
- Medical and surgical history
- Family/genetic history
- Social history, to include tobacco, substance abuse, alcohol, and domestic violence

##### **Physical Examination:**

- Height (annually for Members until they are five years post-menarchal)
- Weight
- Blood pressure
- Head, neck (including thyroid)
- Lymph nodes
- Heart
- Lungs
- Breasts (including instruction in self-examination, reinforcement annually)
- Abdomen
- Back
- Extremities
- Pelvic examination
- Rectal examination, as indicated

#### **Male Members:**

The history and physical examination must include the same general elements, but should be specific for males.

**Office or Member Visit (Follow-up):**

A follow-up visit is allowed for routine contraceptive surveillance, Family Planning counseling/education, contraceptive problems, and suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem (related to a Family Planning annual visit) or follow-up visit the following must occur:

- An update of Member's history
- Physical exam, if appropriate
- Laboratory tests, if appropriate
- Referral to PCP, if appropriate
- Education/counseling, if appropriate

After a contraceptive method is initially provided, the first routine follow-up visit must be scheduled in accordance with the following, unless specifically indicated otherwise:

- Between three and four months for oral contraceptive users (visit must include blood pressure and weight).
- One week and three to four months for implantable Contraceptive Capsules users, according to Protocols (visits must include blood pressure and weight).
- After the next normal menses, or no more than six weeks after they insert an IUD.
- Two and one-half to three months for Depo Provera users.

**1-99429 Initial Member Education:** This visit is to assist in the effective selection of a contraceptive method, and will only be reimbursed once for a new STAR Member, per provider. The provider may repeat the visit no more than once per state fiscal year, per provider. An initial STAR Member Education visit may be billed in conjunction with an annual or follow-up visit.

The visit must be performed as follows: Every new STAR Member requesting contraceptive services or Family Planning must be provided with STAR Member education verbally, in writing, or by audiovisual materials. Over-the-counter contraceptive methods may be provided before the STAR Member receives education, but must be accompanied by written instructions for correct use.

The provider may alter the following initial STAR Member education, according to the educator's evaluation of the STAR Member's current knowledge:

- ✓ General benefits of Family Planning services and contraception.
- ✓ Information on male and female basic reproductive anatomy and physiology.
- ✓ Information regarding particular benefits, potential side effects and complications of all available contraceptive methods.
- ✓ Information concerning all the Member's available services, the purpose and sequence of procedures, and a routine schedule of return visits.
- ✓ Breast self-examination rationale and instructions, unless provided during the physical exam (for females).
- ✓ Information on HIV/STD infection, prevention, and safe sex discussion.

**1-99401 - Method-specific Education/Counseling:** This visit should give the STAR Member information about the contraceptive chosen by the STAR Member, and include proper use, possible side effects, complications, reliability, and reversibility. The provider should provide these services when initiating a method, changing contraceptive methods, or the STAR Member is having difficulty with their current method. This visit can occur along with an annual or follow-up visit. The number of occurrences for this visit will be determined by the number of contraceptive methods chosen by the STAR Member.

Education counseling must include the following:

- ✓ Verbal and written instructions for correct use and self-monitoring of the method chosen.
- ✓ Information regarding the method's mode of action, safety, benefits and effectiveness.
- ✓ Back up method review when appropriate and instructions on correct use.
- ✓ Demonstration of appropriate insertion and removal of a diaphragm or cap at the time of fitting.

**1-99402 Problem Counseling:** This visit deals with situations that do not relate to a contraceptive method. Examples include pregnancy, sexually transmitted diseases, social and marital problems, health disorders, sexuality concerns, and preconception counseling (for an identified problem that could jeopardize the outcome of a pregnancy). This visit may be billed along with an annual or follow up visit. STAR Members who become pregnant (assessment reveals potential pregnancy) must be provided preconception counseling regarding the modification and reduction of that risk.

If a STAR Member requests information about options for an unintended pregnancy or nondirective counseling, then an appropriate referral must be provided for the following:

- ✓ Prenatal care and delivery
- ✓ Infant care, foster care, or adoption

✓ Pregnancy termination (not required of natural Family Planning Agencies)

**1-S9445 Introduction to Family Planning in Hospital Setting/Auspices:** This encounter provides an overview of Family Planning services available to the STAR Member, and encourages pregnant or postpartum women to use such services following their delivery.

**1-H1010 Instruction in Natural Family Planning Methods (per session):** This visit is for either a couple or individual, and may consist of two sessions. When the provider is billing for these services, they must indicate a quantity of two in block 24G of the CMS-1500, or next to the description in field locator 46 on the UB-04, when billing two sessions together.

### **Annual Family Planning Exam and Office Visit**

Procedure Code	Description
1-99203	Office or other outpatient visit for the E & M of a new patient, which requires these three key components: a detailed history; a detailed examination; a medical decision making of low complexity, counseling and/or coordination of care with other providers or agencies are provided.
<b>Or</b>	
1-99214	Office or other outpatient visit for the E & M of an established patient, which requires at least two of these three components: a detailed history, a detailed examination; a medical decision making of moderate complexity, counseling and/or coordination of care.
<b>With</b>	
Modifier FP	Service provided as part of Medicaid Family Planning Program or FP diagnosis.
1-99213	Office or other outpatient visit.

### **Family Planning Diagnosis and Procedure Codes**

**Diagnosis Codes:** Several diagnosis codes are acceptable for billing Family Planning services, however, to simplify the process providers are encouraged to use a single diagnosis with all Family Planning procedures and services. The recommended diagnosis code is “V25.09 - Encounter for contraceptive management, other.”

The following procedure codes are authorized for use when billing Family Planning services:

### **Family Planning Visits:**

1-99213

**Laboratory in Provider's Office:**

**TITLE V and XX**

5-80061	5-81002	5-81015	5-81025	5-81099
5-82465	5-82947	5-83020	5-84478	5-85013
5-85018	5-85025	5-85660	5-86580	5-86592
5-86701	5-86762	5-87070	5-87205	5-87797
5-88150	5-88230	5-88262		

**TITLE XIX**

5-80061	5-81000	5-81002	5-81015	5-81025
5-81099	5-82465	5-82947	5-83020	5-83718
5-83719	5-83721	5-84478	5-84702	5-84703
5-85013	5-85014	5-85018	5-85025	5-85660
5-86317	5-86403	5-86580	5-86592	5-86689
5-86701	5-86702	5-86703	5-86762	5-86781
5-86850	5-86900	5-86901	5-87070	5-87076
5-87077	5-87086	5-87088	5-87110	5-87205
5-87797	5-88142	5-88150	5-88230	5-88262

5-99000 with modifier FP

**Note:** Only the office that performs the laboratory procedure(s) may bill for the laboratory procedure(s). Providers may be reimbursed one lab handling fee per day, per STAR Member, unless the provider obtains multiple specimens and sends them to different laboratories. Lab handling fees will be paid for specimens obtained by venipuncture or catheterization only.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). If providers do not comply with CLIA, Community First Health Plans will not reimburse them for laboratory services.

**Laboratory outside Provider's Office:**

When it is necessary to send a STAR Member out of the provider's office for laboratory services, the provider must direct the STAR Member to a laboratory identified as a Community First Health Plans provider.

**Radiology in Provider's Office:**

4-74000  
4-74010  
4-76815

**NOTE:** Only the office that performs the radiology procedure(s) may bill for the radiology procedure(s).

**Radiology outside Provider's Office:**

When it is necessary to send a STAR Member out of the provider's office for radiology services, the provider must direct the Member to a radiology facility identified as a Community First Health Plans provider.

**Contraceptive Devices and Related Procedures:**

9-A4261	9-A4266	1-J7300	1-J7302	2-11976
2-57170	2-58300	2-58301		

**Drugs and Supplies:**

9-A4261	9-A4266	1-A4267	1-A4268	1-A4269
1-A9150 with modifier FP	1-J1055	1-J1056	1-J3490	
1-S4993				

**Medical Education/Counseling:**

1-H1010  
1-S9445 with modifier FP 1-S9470\*  
1-99401 with modifier FP  
1-99402 with modifier FP  
1-99411 \*\*\*  
1-99429 with modifier FP

\* Title V only

\*\* Title XX only

**Sterilization Services (global fees):**

**Complete:** 1-55250\* 1-58600\*

\*Global fee

**Title V and Title XX only.** For incomplete procedures, one of the following diagnoses must be present on the claim in addition to the diagnosis for sterilization:

V641	V642	V643
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**Tubal Ligation:** 58600

**Vasectomy:** 55250

**Note:** A sterilization consent form and instructions is identified as **(Exhibit 11)** to this Manual. Prior to performing any sterilization procedures, this consent form must be completed in accordance with its instructions.

## **Medical Conditions**

If the Family Planning provider is not the STAR Member's PCP and the STAR Member presents with a "medical condition," the Family Planning provider must refer the STAR Member to their PCP for the appropriate treatment and/or referral for specialty services.



## **IV. BEHAVIORAL HEALTH**

### **A. Definition**

*Behavioral Health Services* means covered services for the treatment of mental or emotional disorders and treatment of chemical dependency disorders.

*An emergency behavioral health condition* means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention without which a STAR Member would present an immediate danger to themselves or others or which renders the STAR Member incapable of controlling, knowing or understanding the consequences of their actions.

### **B. Behavioral Health Covered Services**

- Screening
- Inpatient mental health and substance abuse hospitalization (free standing hospital and general acute-care hospital and Department of State Health Services licensed facilities.)
- Treatment by psychiatrists, psychologists, LPCs, LCSW-ACPs, LMFTs, and LCDCs
- Outpatient Behavioral Health counseling services are available for all STAR members.

### **C. PCP Requirements for Behavioral Health**

PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his practice.

PCP must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

### **D. Behavioral Health Services**

#### **Member Access to Behavioral Health Services**

A STAR Member can access behavioral health services:

- By self-referral to any network behavioral health provider;
- By calling Community First Health Plans at **(210) 358-6100** or **800-434-2347** and obtaining the names of network behavioral health providers

Community First Health Plans does not require that STAR Members have a PCP referral to obtain an initial consultation visit with a network behavioral health provider. Outpatient behavioral health services **beyond** the first 20 visits must be preauthorized by sending the Behavioral Health Request for Authorized Services (**Exhibit 12**) and treatment plan to Community First Health Plans' Health Services Management Department at fax **(210) 358-6387**. Medical necessity documentation must be submitted prior to the 20<sup>th</sup> visit.

A Community First Health Plans nurse available to receive calls 7 days a week, 24 hours a day, including holidays to provide:

- Initial/concurrent review of members admitted to the hospital or receiving services to determine coverage, or
- To assist with obtaining information and checking eligibility.
- To provide preauthorization determinations as requested.

Consultation regarding the appropriateness of the level of care is available through Community First Health Plans' Case Management staff. Psychological/Neuropsychological testing requires preauthorization by faxing the Psychological Testing Request Form (**Exhibit 13**) to **(210) 358-6387**.

### **Coordination between Behavioral Health and Physical Health Services**

Community First Health Plans requires, through provisions of its Professional Provider Agreement that the PCPs will screening and evaluate for the detection and treatment and referral of any known or suspected behavioral health problems and disorders. The PCP will provide any clinically appropriate Behavioral Health Services within the scope of their training and/or practice.

Community First Health Plans is committed to ensuring STAR Members have access to quality behavioral health services that are clinically appropriate and in the most cost-effective setting. Our Behavioral Health network is comprised of psychiatrists, psychologists, social workers, licensed professional counselors, licensed chemical dependency counselors, other licensed mental health professionals, and free-standing psychiatric hospitals and psychiatric units in medical hospitals.

It is critical to the STAR Member's overall health care that the Behavioral Health provider and the Member's PCP communicate regarding relevant

medical information. This interaction should be with the consent of the Member and documented in the Member's medical records.

Community First Health Plans' Case Management staff is available to assist you in identifying and accessing Behavioral Health providers that can meet the needs of your STAR Members. We encourage you to call us with any questions regarding Behavioral Health Service at (210) 358-6100 or 800-434-2347.

### **Medical Records Documentation and Referral Information**

When assessing a STAR Member for behavioral health services, providers must use the DSM-IV multi-axial classification and report axes I, II, III, IV and V. Community First Health Plans may require use of other assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and the assessment/outcome information in the STAR Member's medical record.

All network PCPs must ensure all STAR Members receive a screening, evaluation, and referral and/or treatment for any identified behavioral health problems or disorders.

### **Consent for Disclosure of Information**

A written medical record release must be obtained from the STAR Member, or a parent or legal guardian of the STAR Member, before the provider can send the STAR Member's Behavioral Health Report to the PCP. The STAR Member will be advised that he/she is not required to sign the release and treatment will not be denied if the STAR Member objects to signing the form. The provider will place a copy of the signed release in the STAR Member's record.

### **Court Ordered Commitments**

Community First Health Plans must provide inpatient psychiatric services to STAR Members under the age of 21 whom the court of competent jurisdiction has ordered to receive the services under the provision of Chapter 573 and 574 of the Texas Health and Safety Code, which relates to court ordered commitments to psychiatric facilities.

Community First Health Plans cannot deny, reduce or controvert the medical necessity of any court ordered inpatient psychiatric service for STAR Members under age 21. Any modification or termination of court ordered services for STAR Members must be presented to the court with jurisdiction over the matter to make a determination.

A STAR Member who has been ordered to receive treatment under the provisions of Chapter 573 and 574 of the Texas Health and Safety Code

*cannot* appeal the commitment through Community First Health Plans complaint and appeals process.

### **Coordination with the Local Mental Health Authority**

Providers rendering behavioral health services who believe STAR Members qualify for target case management or rehabilitation services through the Local Mental Health Authority (LMHA), may refer the member to the LMHA office nearest to the STAR Member. The LMHA will assess the STAR Member to determine if they meet criteria for Severe and Persistent Emotional Disturbance (SPMI) or Severe Emotional Disturbance (SED). For LMHA information, call the Center for Healthcare Services (210) 713-1300.

A provider, with written consent from the STAR Member, should inform the LMHA providing rehabilitation services or target case management that the STAR Member is receiving behavioral health services.

### **Assessment instruments for Behavioral Health available for PCP use**

Community First Health Plans requires, through provisions in its Professional Provider Agreement, that a Member's PCP have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their training and practice.

Community First Health Plans will provide or arrange for training for network PCPs on how to screen and identify behavioral health disorders, Community First Health Plans referral process for Behavioral Health Services and clinical coordination requirements for such services. Community First Health Plans will provide general assessment tools for PCPs as they are developed.

### **Focus Studies and Utilization Management Reporting Requirements**

As part of the utilization management report submitted by Community First Health Plans to HHSC on a quarterly basis, Community First Health Plans includes behavior health utilization data. Each report has a standardized reporting format and detailed instructions that DSHS may periodically update to include new codes, which will allow better communication between Community First Health Plans and HHSC.

To meet this reporting requirement, Community First Health Plans might include providers who render behavioral health services to STAR Members in a behavioral health medical record audit.

### **Procedures for Follow-up on Missed Appointments**

Community First Health Plans requires that all providers contact STAR Members, if they miss a scheduled appointment, and reschedule such appointment within 24 hours of missed appointment.

### **Discharge Planning and Aftercare**

Providers must notify a Community First Health Plans' Case Manager when they discharge a STAR Member from an inpatient, residential treatment, partial hospitalization, or intensive outpatient setting. STAR Members should have a copy of the discharge plan, which includes an aftercare appointment or entry into a lesser level of care.

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 days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments.

### **E. Behavioral Health Screening and Assessment**

When assessing STAR Members for behavioral health services, providers must use the DSM-IV multi-axial classification and report axes I, II, III, IV, and V. Community First Health Plans may require use of other assessment instruments/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the STAR Member's medical record.

All network PCPs must ensure all STAR Members receive a screening, evaluation, and referral and/or treatment for any identified behavioral health problems and disorders.

### **F. Summary Reports to Primary Care Providers**

All providers rendering behavioral health services to STAR Members must send completed Behavioral Health Reports to the PCP upon beginning behavioral health services and every three months that the STAR Member remains in treatment and/or upon discharge. A copy of the report will be placed in the STAR Member's permanent record.

### **G. Community First Health Plans is responsible for authorized inpatient Hospital services including services provided in Freestanding Psychiatric Facilities.**

## **V. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM**

### **Introduction**

Community First Health Plan's Quality Management and Improvement Program (QMIP) is an integrated, comprehensive program that incorporates review and evaluation of all aspects of the health care delivery system. Components of this program include problem focused studies, peer review, risk management, credentialing, compliance with external regulatory agencies, utilization review, 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 STAR Members.

The QMIP is under the supervision of the Director of Legal and Regulatory Affairs, the Medical Director and the Quality Improvement Committee.

### **A. Delegation of QMIP Activities**

Community First Health Plans does not delegate any QMIP management activities.

Providers who have been delegated activities, such as credentialing and/or utilization review, are required to have quality improvement programs in place, which meet all the requirements of Community First Health Plans and/or regulators.

As specified in the Administrative Delegated Service Agreement, the 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. These entities are audited annually for compliance with the Community First Health Plans QMIP. If necessary, quality improvement plans are initiated by Community First Health Plans with defined outcomes and deadlines.

### **B. Practice Guideline Development**

Community First Health Plans has established a process for evaluating patterns of care for specific conditions and procedures. Adult Preventive Care guidelines have been developed by the Quality Improvement Committee. Compliance with the guidelines is evaluated during the medical record reviews. The Quality Improvement Committee approved practice guidelines for both Asthma and Diabetes, and they will be used to assess the quality of health care delivery for

these disease entities. Other practice guidelines may be developed and approved by the Quality Improvement Committee.

The success of the QMIP depends upon your cooperation by:

- Providing us with medical records concerning our STAR Members upon request;
- Maintaining the confidentiality of STAR 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 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.

### **C. Focus Studies and Utilization Management reporting Requirements**

In addition to any focus studies performed on behalf of DSHS, Community First Health Plans performs focus studies as part of the QMIP to objectively and systematically monitor and evaluate the quality of care and service provided to Community First Health Plans members. The studies are performed based on topics and tools agreed upon by the Quality Improvement Committee. Providers are notified of audits (if medical record review is necessary) at least two weeks in advance. Study findings are submitted to providers, and if indicated, quality improvement plans are initiated by Community First Health Plans with defined outcomes and deadlines.

Provider agrees to comply with the Community First Health Plans' termination Program requirements. Provider understands and agrees that any provider performance data gathered by Community First Health Plans as part of its QMIP Program may be published on its website or other such reports.

## **VI. PROVIDER RESPONSIBILITIES**

### **A. PCP (Medical Home) Responsibilities**

PCPs function as the medical home for Community First Health Plans STAR Members.

Provider agreement with the Texas Health and Human Services Commission (HHSC) or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). Medicaid Providers must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2008.)

**PCPs are responsible for reporting suspected child abuse or neglect.**

At the request of the Texas Health and Human Services Commission (HHSC) and The Department of Family and Protective Services (DFPS), providers must testify in court as needed for Child protection litigation.

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:

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

PCPs are responsible for arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers.

1. Comply with applicable state laws, rules and regulations and the Texas Health and Human Services Commission (HHSC) request regarding personal and professional conduct generally applicable to the service locations
2. Otherwise conduct themselves in a businesslike and professional manner.

PCPs are responsible for the appropriate coordination and referral of Community First Health Plans STAR Members for the following services:

- CPW case management service;
- DARS case management services;



- ECI Case Management services;
- MR targeted case management;
- SHARS
- Texas Commission for the Blind case management services;
- Texas Health Steps medical case management
- Texas Health Steps dental (including orthodontics);
- Tuberculosis services; and
- Community First Health Plans' Pharmacy Program through *Navitus*

## **B. Availability and Accessibility**

Network PCPs must be accessible to STAR Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network PCPs after normal business hours.

### ***Acceptable:***

1. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and who can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. 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. A second recorded message is not acceptable.
3. 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.

### ***Unacceptable:***

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

## **Access and Availability Standards**

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

Community First has Primary Care Physicians (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 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.

<b>TYPE OF APPOINTMENT</b>	<b>APPOINTMENT AVAILABILITY</b>
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 inpatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments.
Initial Outpatient Behavioral Health visits	Within 14 days of request
Routine Specialty Care Referrals	Within 30 days of request
Physical Examinations	56 days or less (4 - 8 weeks)
Prenatal Care (Initial)	14 calendar days or less or by the 12 <sup>th</sup> week

<b>TYPE OF APPOINTMENT</b>	<b>APPOINTMENT AVAILABILITY</b>
	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.
Well-Child Care  Well adolescent care	Routine Well-Child Care: Within 14 days of request  Routine Well Adolescent Care: Within 14 days of request
Texas Health Steps Medical Checkups	Within 14 days of request
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 14 days of request
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,	Within 2 hours for IV therapy or oxygen

TYPE OF APPOINTMENT	APPOINTMENT AVAILABILITY
ST SNV, etc.)	therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection.
Provider office waiting time	Within 30 minutes of scheduled appointment time.
Requests for feedback from pharmacy related to prescriptions	Within 24 business hours

### C. Plan Termination Process

Community First Health Plans or the participating Provider may terminate their contractual Agreement as of any date by giving written notice of at least sixty (60) days in advance. The parties may, however, agree to an earlier termination date. Community First Health Plans may also terminate this Agreement immediately upon notice to the Provider, in the event of Community First Health Plans' determination that the health, safety or welfare of any STAR Member may be in jeopardy if the Agreement is not terminated. Providers may refer to the Term and Termination section of their Professional Provider Agreement for more information.

Provider's contract contains Community First Health Plans' process for terminating Provider contract.

Community First Health Plans follows the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a provider, including an STP. At least 90 days before the effective date of the proposed termination of the provider's contract, Community First Health Plans will provide a written explanation to the provider of the reasons for termination. Community First Health Plans may immediately terminate a provider contract in a case involving: (1) imminent harm to patient health; (2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the provider's ability to practice medicine, dentistry, or another profession, or (3) fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, a provider may request a review from 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 license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the

provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee from Community First Health Plans. The decision of the advisory review panel must be considered by Community First Health Plans but is not binding of Community First Health Plans . Within 60 days following receipt of the provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Community First Health Plans will communicate its decision to the provider. Community First Health Plans will provide to the affected provider, upon request, a copy of the recommendation of the advisory review panel and Community First Health Plans' determination.

### **Termination 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 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 the Provider contract at any time for violation of this requirement.

### **D. Member's Right to Designate an OB/Gyn**

Community First Health Plans' does not limit your selection of an OB/Gyn to your PCP's network.

Female Members have the right to select an OB/Gyn without a referral from their PCP. The access to health care services of an OB/Gyn includes:

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

### **E. Advance Directives**

Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

It's the Members right to accept or refuse medical care. Advance directive can protect this right if they ever become mentally or physically unable to choose or communicate their wishes due to an injury or illness. To request additional information or to request a brochure about advance directives the Member can contact Member Services at (210) 358-6060 or toll-free at 800-434-2347.

## **F. Referral to Specialists and Health Related Services**

PCPs are responsible for assessing the medical needs of STAR Members for referral to specialty care providers and to provide referrals as needed. The PCP must coordinate Member's care with the specialty care providers after referral. Community First Health Plans will assess PCP's actions in arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers.

## **G. PCP & Behavioral Health Related Services**

A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his training and/or practice.

## **H. Referral to Network Facilities and Contractors**

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) 358-6200** 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 continuity and quality of care.

Community First Health Plans requires preauthorization for court mandated inpatient psychiatric care for STAR Members under age 21, however, the HMO will not deny reduce or controvert the medical necessity of any physical or behavioral health care services included in an order entered by the court with respect to a child in the conservatorship of the Texas Department of Child Protective Services.

**Note: Payment for services requiring notification or preauthorization is contingent upon verification of current eligibility and applicable contract specifications at the time of service. For verification of eligibility call (210) 358-6060.**

## **I. Access to Second Opinion**

- Have access to second medical opinion from a network provider, or an out of network provider at no additional cost to the member, if a network provider is not available.

- Members with Disabilities/Special Health Care Needs, chronic or complex conditions are allowed to have direct access to a specialist. The network specialist must agree to perform all PCP duties, and such duties must be within the scope of the participating specialist's certification. Please refer to the page 9, Section C, of Provider Manual for further information.

## **J. Specialty Care Provider Responsibilities**

### **Availability and Accessibility**

Network Specialists must be accessible to STAR Members 24 hours a day, 7 days a week, or make other arrangements for the provision of availability and accessibility. The following are acceptable and unacceptable phone arrangements for network specialists after normal business hours.

#### **Acceptable:**

1. Office phone is answered after hours by an answering service, which meets language requirements of the major population groups, and who can contact the specialist or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. 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 network provider designated by the specialist. Someone must be available to answer the designated network provider's phone. A second recorded message is not acceptable.
3. 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 network provider.

#### **Unacceptable:**

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

## ACCESS STANDARDS

<b>TYPE OF APPOINTMENT</b>	<b>APPOINTMENT AVAILABILITY</b>
Emergency Care, including Behavioral Health	24 hours a day, 7 days a week, upon Member presentation at the deliver site, including non-network and out-of-area facilities.
Urgent Care (PCP) (Specialist) (Behavioral Health)	Within 24 hours of request Within 24 hours of request Within 24 hours of request
Routine Care (PCP) (Specialist) (Behavioral Health) Routine/schedule inpatient/outpatient care	14 days or less of request 14 days or less of request 14 days or less of request
Behavioral Health Discharge Planning/Aftercare	Members discharged from an inpatient setting must have a scheduled follow-up outpatient appointment within seven (7) days after discharge. Members should be strongly encouraged to attend and participate in aftercare appointments.
Initial Outpatient Behavioral Health visits	Within 14 days of request
Routine Specialty Care Referrals	Within 30 days of request
Physical Examinations	56 days or less (6-8 weeks)
High-risk pregnancies or new members in the third trimester	Within 5 days or immediately if an emergency exist.
Well-Child Care (Including Texas Health Steps) and Well-adolescent Care	STAR Well-Child/Texas Health Steps: Within 14 days of request Routine Well-child and well-adolescent Care: Within 14 days of request
Texas Health Steps Checkups	Within 14 days of request
Children of Migrant Farm Workers	Staff must ensure prompt delivery of services to children of migrant farm workers and other



	migrant population who may transition into or out of HMO program more rapidly and/or unpredictable than the general population.
Newborn Care (in a hospital)	Newborns must receive an initial newborn checkup before discharge from the hospital.
Newborn Care (after discharge from a hospital)	Within 14 days of hospital discharge.
Preventive Health Services for Children and Adolescents	Within 14 days of request
Preventive Health Services for Adults	Within 90 days of request in accordance with US Preventive Services Task Force recommendations
Physical Therapy	Within 24 hours (urgent) 3 days or less (routine) 14 days or less (follow-up)
Radiology	Within 24 hours (urgent) 7 days or less (MRI/CT Scan) 10 days or less (IVP/UGI) 21 days or less (Mammogram)
Home Health/DME/Supplies (OT, PT, ST SNV, etc.)	Within 2 hours for IV therapy or oxygen therapy. Within 24 hours for standard nursing care and delivery of non-urgent equipment. Significant changes in health status of the patient are to be relayed to the attending physician within 4 hours of detection.
Provider office waiting time	Within 30 minutes of scheduled appointment time.
Request for feedback from pharmacy related to prescriptions	Within 24 business hours

#### **K. Verify Member Eligibility and/or Authorization for Services**

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

Each STAR Member is issued a Texas Benefits Medicaid Card (**Exhibit 3**), and a Plan (i.e., Community First Health Plans) ID Card. We instruct the STAR Member to present both ID Cards when requesting services. The Community First Health Plans ID Card (**Exhibit 4**) shows important Member information and important Community First Health Plans telephone numbers.

At the time of the visit ask the Member to show both forms of ID. The Texas Benefits Medicaid Card will verify coverage for the current month only, and will also identify if the holder is a STAR Member, and name of the Plan. The Community First Health Plans' ID card and Medicaid ID Forms do not guarantee eligibility for coverage. To verify eligibility log on to Community First Health Plan's Provider Portal ([www.cfhp.com](http://www.cfhp.com), select the "Provider Login" option) or call Member Services Department at (210) 358-6060. Eligibility may also be obtained through TMHP's Automative Inquiry System (AIS) or TMHP's Electronic Data Interchange (EDI). If conflicting PCP information is found, please contact Community First Health Plans Member Services Department for assistance. Providers must document this verification in their records and treat the client as usual.

PCP information is not shown on the Texas Benefits Medicaid Card and is only printed on the Community First Health Plans' ID card. Listed below are helpful ways to verify eligibility:

- Member services Department at (210) 358-6060 (outside Bexar County 800-434-2347)
- Community First Health Plans Provider Web Portal.
- Temporary ID (Form 1027A) which is issued when the member's Texas Benefits Medicaid Card is lost or stolen or temporary emergency Medicaid is granted.
- AISLine at (512) 345-5949, or 800-925-9126

If a Member has questions about benefit coverage or wants to change to a different PCP, please ask him or her to call our Member Services Department at **(210) 358-6060**. Community First Health Plans will arrange for all covered services for the period STAR Members are eligible with Community First Health Plans, except as follows:

- *Inpatient admissions prior to enrollment with Community First Health Plans:* Community First Health Plans is responsible for physician and non-hospital services from the date of enrollment with Community First Health Plans. Additionally, Community First Health Plans is not responsible for any hospital charges for Members admitted prior to enrollment with Community First Health Plans.
- *Inpatients after enrollment with Community First Health Plans:* Community First Health Plans is responsible for services until they discharge the STAR Member from the hospital, unless the STAR Member loses Medicaid or STAR eligibility.

- *Discharge after voluntary disenrollment from Community First Health Plans and re-enrollment into a new STAR HMO:* Community First Health Plans remains responsible for hospital charges until the STAR Member is discharged from the facility. The new STAR HMO is responsible for physician and non-hospital charges beginning on the effective date of enrollment into the new STAR HMO.
- *Newborns:* Community First Health Plans is responsible for all covered services related to the care of a newborn child from the date of birth, if the mother is enrolled with the Community First Health Plans STAR Program at the time of birth.
- *Hospital Transfers:* Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment should not be considered as discharged under this section.
- *Psychiatric Care:* Inpatient psychiatric care, in a freestanding psychiatric facility for STAR Members under age 21, is Community First Health Plans' responsibility from the Member's date of enrollment with Community First Health Plans.

**Note:**

Community First Health Plans' responsibilities shown above are subject to the contractual requirements between Community First Health Plans and provider (i.e., referral and claims submission requirements).

**The PCP is responsible for initiating all referrals to specialty care providers (see section on Referral Notification).**

Community First Health Plans currently requires preauthorization for services listed on the authorization list(See **Exhibit 7**). 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.

**If the provider seeking authorization is a Specialty Physician, communication must be provided to the PCP regarding services rendered, results, reports and recommendations to ensure continuity of care.**

**Note:** Pre-authorizations are generally valid for 30 days from the date issued; this timeframe may be extended based on the type of request. 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. Providers cannot bill STAR Members for covered services.

PCPs and specialists may request preauthorization as follows:

- Call Community First Health Plans' Health Services Management Department at **(210) 358-6050**.
- Fax the completed **Texas Referral/Authorization form (Exhibit7)** to **(210) 358-6040**.
- Submit secure electronic requests using Community First Health Plans online medical management portal. (Contact Community First Health Plans Network Management Department at (210) 358-6030 or email [nmcfhp@cfhp.com](mailto:nmcfhp@cfhp.com) for access)

The Health Services Management Department is available to answer the preauthorization telephone lines from 8:30 a.m. to 5:00 p.m. CST. After hours and on weekends or holidays we will accept either your fax or phone message as meeting notification requirements, however, authorization of the services listed on the preauthorization list will need to meet eligibility, medical necessity review and benefit criteria prior to issuance of an authorization number. You may call Community First Health Plans to check on the status of your preauthorization request at (210) 358-6050 during regular business hours.

Please have the following information available when requesting pre-authorization:

- ✓ Member's name and ID Number
- ✓ Primary diagnosis with ICD-9 Code, if known
- ✓ Surgery/Procedure with CPT Code, or purpose and number of visits
- ✓ Anticipated date of service or admission date
- ✓ Name of consultant/facility
- ✓ Clinical information to support the requested service
- ✓ Expected length of stay (inpatient only)

Our Health Services Management Department will issue an authorization number for approved requests after eligibility, medical necessity and benefit criteria has been determined. Faxed requests will be faxed back to the requesting provider including the authorization number if the service/s has been approved. Telephone requests will receive an authorization telephonically if the service/s is being approved.

If we place a request in pending status 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 by our Medical Director or Clinical Consultant for lack of requested information.

We will deny requests that do not meet eligibility, benefit criteria, or medical necessity criteria. Community First Health Plans will afford the requesting Provider reasonable opportunity to discuss with the Medical Director or Clinical Consultant, the plan of treatment and the clinical basis for the decision, as well as, the opportunity to provide additional information that may be pertinent prior to the issuance of an adverse determination. We will notify the provider by phone and letter, either by fax or mail, within 48 hours. The STAR Member is sent a denial letter by mail. If the authorization request is denied based on medical necessity, the provider can appeal the decision on behalf of the member. The appeal information will be on the denial letter.

#### **L. Continuity of Care**

##### **For Pregnant Women:**

Pregnant members with twelve weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery will be allowed to stay under the care of the members current OB/Gyn through the members postpartum checkup even if the provider is out of network. If the member wants to change her OB/Gyn to one who is in the plan, she will be allowed to do so if the provider to whom she wishes to transfer agrees to accept her in the last trimester. **(Exhibit 1)**

##### **For Member that Moves Out-of-Area:**

Community First Health Plans will reimburse out of network providers for covered services rendered to STAR Members who move out of Community First Health Plan's service area through the end of the period for which a premium has been paid for the member.

Preauthorization must be obtained for all out of network services. Requests for preauthorization can be submitted by fax to: Community First Health Plan's Health Service Management Department at (210) 358-6040 or requested by phone to: (210) 358-6050.

##### **For Pre-existing Conditions:**

Community First Health Plans is responsible for arranging for the provision of all covered STAR services to each eligible Community First Health Plans STAR Member beginning on the STAR 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 STAR services will be in accordance with contractual requirements between Community First Health Plans and the provider.

#### **M. Transition of Care**

Community First Health Plans will ensure that the care of newly enrolled Community First Health Plans STAR Members is not unreasonably disrupted or interrupted to the magnitude that the STAR Member's health could be placed in jeopardy, if such care is disrupted or interrupted. Community First Health Plans provides STAR Members with a process to request continuation/transition of ongoing care and use of a specialist as the PCP under certain circumstances. Through collaboration with Community First Health Plans' Case Managers, STAR Members with medical or behavioral disabilities or chronic/ complex conditions are encouraged to maintain a stable "medical home."

Transition of care: Any treatment rendered by a non-participating physician or a Community First Health Plans specialist prior to a new STAR Member's effective date and is expected to continue for 90 days following the effective date of the plan.

Continuity of care: Care provided to a STAR Member by the same primary care provider or specialty provider to the greatest degree possible, so that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

PCPs and specialists can call our Health Services Management Department at **(210) 358-6050** to address any continuity/transition of care issues, or fax the **Request for Continuity/Transition of Care** form (**Exhibit 1**) to **(210) 358-6040**.

#### **N. Medical Records Documentation Guidelines**

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.

Community First Health Plans follows guidance from the Centers for Medicare and Medicaid regarding 1997 CMS documentation and coding guidelines, the National Correct Coding Initiative, Global Surgical Period and

Physician Signature Guidelines in addition to current *American Medical Association (AMA) Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-9)*. The Texas Medicaid Provider Procedures Manual also recognizes guidelines from the Centers for Medicare and Medicaid regarding medical record documentation standards for coding and billing.

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) and the International Classification of Diseases, 9<sup>th</sup> Revision Clinical Modification (ICD-9 CM) systems be used to report professional services, including physician services and diagnoses. Correct use of CPT and ICD-9 coding requires using the most specific code that matches the services provided and illnesses 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.

#### **Amendment to Medical Records:**

Community First Health Plans follows the Texas Administrative Code, Title 22, Part 9 Chapter 165 Rule §165.1 guidelines for the amendment of medical records.

- The provider must have specific recollection of the services provided which is documented.
- A provider may add a missing signature without a time restriction if the provider created the original documentation him/herself.
- The above does not restrict or limit the provider's ability to document or amend medical records at any time to more accurately describe the clinical care provided to the patient.
- For medical record review/audit and reimbursement purposes, documentation is not considered appropriate and/or timely documented if originally completed after thirty (30) days of the date of service.

#### **Definitions:**

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

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

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

#### **O. Justification regarding Out of Network Referrals**

Community First Health Plans' requirements concerning treatment of members by Out-of-network providers are as follows:

1. Community First Health Plans shall allow referral of its member(s) to an out-of-network provider, shall timely issue the proper authorization for such referral, and shall timely reimburse the out-of-network provider for authorized services provided when:
  - a. Medicaid covered services are medically necessary and these services are not available through an in-network provider.
  - b. A provider currently providing authorized services to the member requests authorization for such services by an out-of-network provider
  - c. The authorized services are provided within the time period specified in the authorization issued by Community First Health Plans. If the services are not provided within the required time period, a new request for preauthorization from the requesting provider must be submitted to Community First Health Plans prior to the provision of services.
2. Community First Health Plans may not refuse to reimburse an out-of-network provider for emergency or post-stabilization services provided as a result of the Community First Health Plans failure to arrange for and authorize a timely transfer of a member to an in-network facility.
3. Community First Health Plans' requirements concerning emergency services are as follows:



- a. Community First Health Plans shall allow its members to be treated by any emergency services provider for emergency services and/or for services to determine if an emergency condition exists.
  - b. Community First Health Plans is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.
4. Community First Health Plans may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described above.

**Reasonable Reimbursement Methodology:**

Community First Health Plans has been reimbursing Out Of Network Providers in accordance with Texas Administrative Code (TAC) at Title 1, Part 15, Chapter 355:

- a. prior to the 02/20/2010 change Out Of Network In-Area providers were paid Medicaid rates minus 3%; Out Of Network/Out Of Area Providers were reimbursed at 100% of current Medicaid rate
- b. For a Date of Service on or after 02/20/2010 Out Of Network/In-Area providers were reimbursed at Medicaid minus 5% in accordance with the change in Texas Administrative Code (TAC) at Title 1, Part 15, Chapter 355
- c. Out Of Network/Out Of Area Providers are reimbursed at 100% of Medicaid rate

**P. Optometry and Ophthalmology Services**

Members have the right to select and have access to, without a Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery.

**Q. Access to Medication**

Member's right to obtain medication from any Network pharmacy.

**R. How to Help a Member Find Dental Care.**

The Dental Plan Member ID card will lists the name and phone number of a Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the

Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid Enrollment Broker's toll-free telephone number at 800-964-2777.

#### **S. Confidentiality**

Provider must treat all information that is obtained through the performance of the services included in 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 may 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 contract.

#### **T. Fraud and Abuse**

Provider understands and agrees to the following:

1. 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;
2. Requests for information from such entities must be complied with, in the form and language requested;
3. 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, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense; and
4. Compliance with these requirements will be at the Provider's expense
5. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid Programs, as applicable;
6. Providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;

7. Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector 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;
8. If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
9. 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.

If the Provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), the provider must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.
2. Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

**U. Insurance**

Provider shall maintain, during the term of the 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 Provider has admitting privileges.

NOTE: This provision will not apply if the 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.

**V. Marketing**

Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual.

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 Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

**W. Provider Network Requirements**

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

**X. 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.

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:

- ✓ Member survey results
- ✓ Complaints and Grievances

- ✓ Utilization data
- ✓ Compliance of Community First Health Plans policies & procedures
- ✓ An office site review and evaluation
- ✓ A medical record audit

### **Advance Nurse Practitioner Requirements**

To be a provider of Medicaid covered services, an Advance Nurse Practitioner must:

- Be licensed by the Texas State Board of Nurse Examiners
- Be licensed by the licensing authority as an Advance Nurse Practitioner
- Comply with all applicable Federal and State Laws and regulations governing the services provided
- Be enrolled and approved for participation in the Texas Medical Assistance Program
- Sign a written provider agreement with the department or its designee
- Comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards and guidelines published by the department or its designee
- Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the department or its designee.

### **Advance Nurse Practitioner Benefits and Limitations**

Subject to the specifications, conditions, requirements and limitations established by the department or its designee, services performed by Advance Nurse Practitioners are covered if the services:

- Are within the scope of practice for Advance Nurse Practitioners, as defined by state law
- Are consistent with rules and regulations promulgated by the Texas State Board of Nurse Examiners or other appropriate states licensing authority
- Would be covered by the Texas Medical Assistance Program if provided by a licensed physician (MD or DO)

To be payable, services must be reasonable and medically necessary as determined by the department or its designee.

Advance Nurse Practitioners who are employed or remunerated by a physician, hospital, facility or other provider must not bill the Texas Medical Assistance Program directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital or other provider (if the provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses Advance Nurse Practitioners. The basis and amount of Medicaid reimbursement depend on the services actually provided, who provided the services and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the providers involved.

The policies and procedures in this subchapter do not apply to certified registered nurse anesthetists and certified nurse-midwives. Coverage of services provided by certified nurse-midwives and certified registered nurse anesthetists are described in subchapters Q and V of this chapter (relating to Nurse-Midwife Services and Certified Registered Nurse Anesthetists Services).

### **On-Site Reviews**

As part of our QMIP, we will be conducting periodic facility and medical record audits for PCPs who have 50 or more Community First Health Plans Members. The reviews are used in the re-credentialing process. 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 three years. You will be notified of the scheduled audit by the Quality Management Department prior to the review. The audit routinely consists of four components:

- Documentation
- Continuity of Care
- Preventive Care
- Facility Site Review

A copy the Medical Record Review Tool (**Exhibit 15**), and the Preventive Services for Adults (**Exhibit 17**) 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. Those areas with scores below the established benchmarks will be required to adopt a Corrective Action Plan. The Community First Health Plans Quality Management Department may provide educational assistance with medical record documentation, if desired. 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 standards.

**Y. Updates To Contact Information**

Providers must inform both Community First Health Plans and HHSC's administrative services contractor of any changes in the Provider's address, telephone number, group affiliation, etc.

## **VII. COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)**

Community First Health Plans must cooperate and 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.

Community First Health Plans providers must do the following:

- Report any confirmed or suspected cases of abuse and neglect to DFPS.
- Provide medical records at the time the records are requested.

Community First Health Plans will continue to provide all covered services to a STAR Member receiving services from or in the protective custody of DFPS until the STAR Member has been dis-enrolled from Community First Health Plans as a result of loss of eligibility or placement into foster care.

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:

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



## VIII. ROUTINE, URGENT AND EMERGENCY SERVICES

### A. Definitions

*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 STAR Member's condition, sickness, or injury is of such matter that failure to get immediate care could result in:

- Placing the STAR Member's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction to any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

**Community First Health Plans should be notified of emergency transportations, admissions 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 STAR Member must contact his or her PCP to arrange any non-emergency care needed. If the STAR Member is hospitalized in a non-participating hospital as a result of an emergency medical condition, the STAR Member may be transferred to a network hospital as soon as stabilization occurs and 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. Community First Health Plans will process all requests for authorization of post-stabilization services within one (1) hour of receiving the request.

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 STAR Member's PCP or PCP designee to prevent serious deterioration of the STAR Member's condition or health.

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 **Nurse Advice Line, (210) 358-3000, or 800-434-2347**, a **24-hour** nurse advice service staffed by registered nurses who provide advice according to written protocols, and assist STAR Members in accessing treatment.

Services provided at the Urgent Care Clinics are limited to:

- **After Hours Urgent Care**

Weekdays/Weekends	5:00 p.m. - 8:30 a.m.
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Holidays	
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Day Preceding a Holiday:	After 5:00 p.m.
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Day Following a Holiday	Before 8:30 a.m.
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- **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.

- **Requirements for Scheduling appointments**

**Referrals to the Urgent Care Clinic:** When referring a STAR 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 STAR 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 STAR 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.

**Routine/Non-Emergent Condition.** 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. Emergency Transportation**

According to 1 TAC §354.1111, an emergency transport is a service provided by a Medicaid-enrolled ambulance provider for a Medicaid client whose condition meets the definition of an emergency medical condition. Conditions requiring cardio pulmonary resuscitation (CPR) in transit or the use of above routine restraints for the safety of the client or crew are also considered emergencies. Facility-to-facility transfers are appropriate as emergencies if the required emergency treatment is not available at the first facility.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, and loss of consciousness, semi consciousness, and seizure or with receipt of CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria.

Emergency transports do not require prior authorization.

## **C. Non-Emergency Transportation**

Non-emergency transportation services are available to eligible Medicaid clients who have no other means of transportation. This service is known as the Medical Transportation Program (MTP) and is detailed in "Medical Transportation" section.

#### **D. Member/Client Acknowledgment Statement**

Provider may not bill a STAR Member for covered services, which we determine are not medically necessary, unless you obtain the Member's prior, written, informed consent. The Member's consent will not be considered informed, unless you explain to the Member before you render the services that Community First Health Plans will not pay for the services, and that the Member will be financially responsible.

A provider may bill the STAR Member for a service if both of the following conditions are met:

- The patient requests the specific service.
- The provider obtains a **Member/Client Acknowledgment Statement** signed by the patient and the provider. (**Exhibit 16**)

The provider must obtain and keep a written **Member/Client Acknowledgment Statement** signed by the client that states:

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

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

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of the Texas Medicaid Program (for example, personal care items).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-

covered days. Spell of illness limitations do not apply to medically necessary stays for Texas Health Steps-eligible clients younger than age 21 years.

- The reduction in payment that is because of the medically needy spend down (effective September 1, 2003, the Medically Needy Program (MNP) is limited to children younger than age 19 years and pregnant women). The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted.

#### **E. Private Pay Form Agreement**

A Participating Physician and/or provider may bill a STAR Member only if:

- A specific service or item is provided at the STAR Member's request;
- The provider has obtained and kept a written Private Pay Agreement signed by the client. (**Exhibit 21**)

The Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay Agreement from the STAR Member. Without written, signed documentation that the STAR Member was properly notified of the private pay status, PCP and/or Participating Provider cannot seek payment from an eligible STAR Member.

If the Member is accepted as a private pay patient pending Medicaid eligibility determination and the Member does *not* become eligible for Medicaid retroactively. The PCP and/or Participating Provider are allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactive, the member will notify the provider of the change in status. Ultimately, the provider is responsible for filing claims timely to Community First Health Plans. If the Member becomes eligible, the provider *must* refund any money paid by the client and file claims for all services rendered to Community First Health Plans, if appropriate.

A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from the Texas Medicaid Program and termination from network participation with Community First Health Plans.

**IMPORTANT:** Ancillary services must be coordinated and pertinent eligibility information must be shared. The PCP is responsible for sharing eligibility information with others.

#### **F. Emergency Prescription Supply**

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

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

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

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

Contact Navitus Health Solutions' Provider Hotline at phone# 877-908-6023

Call Navitus Health Solutions' Provider Hotline 877-908-6023 for more information about the 72-hour emergency prescription supply policy.

## **IX. PROVIDER COMPLAINTS/APPEALS PROCESS**

### **A. Provider Complaints to Community First Health Plans**

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.

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 with a transmittal letter (**Exhibit 23**). The provider must complete the form and return the form to Community First Health Plans for prompt resolution of the complaint. Once the Provider Complaint Form is received by Community First Health Plans, a letter will be sent acknowledging receipt of the complaint within five (5) working days from the date of receipt.

Following investigation of the complaint, the Network Management Department will send a letter to communicate Community First Health Plans' resolution of the complaint to the provider within thirty (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 five (5) working days from the date of receipt.

Community First Health Plans will send written notification within thirty (30) calendar days from the receipt of the appeal to the provider of the acceptance, rejection or modification of the Provider's appeal and proposed resolution. This notification will constitute Community First Health Plans' final determination. The notification will advise the provider of his or her right to submit the complaint 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.

### **B. Provider Appeals to Community First Health Plans**

If you wish to appeal a decision made by Community First Health Plans that the health care services furnished or proposed to be furnished to a STAR Member are not medically necessary, you or the Member may appeal orally, followed up with a written appeal, or in writing.

Adhere to the following process when appealing:

1. Within (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 that need to be submitted to Community First Health Plans for the appeal.
2. When Community First Health Plans receives an oral appeal, 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 hospital 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 one (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 sought review of the appeal, we will provide written notification to the Member, Member's Representative, and the 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 thirty (30) days after we receive the oral or written request for appeal. 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 Fair Hearing (See Member Complaints and Appeals section).

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

**C. Provider Complaint Process to HHSC**

A provider, who believes they did not receive full due process from Community First Health Plans, may file a complaint with HHSC. HHSC is only responsible for the management of complaints. Appeal, hearing or dispute resolutions are the responsibility of Community First Health Plans. Providers must exhaust the appeals/complaint process with Community First Health Plans before filing a complaint with HHSC.

Complaints must be received by HHSC. Providers should refer to the Texas Medicaid Provider Manual for specific information on complaint requirements.

The 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.

Complaints should be mailed to the following address:

**Texas Health and Human Services Commission  
Re: Provider Complaint  
Health Plan Operations, H-320  
PO Box 85200  
Austin, Texas 78708**

## **X. MEMBER COMPLAINT/APPEAL PROCESS**

### **A. Member Complaint/Appeal Process:**

A complaint is an expression of dissatisfaction expressed orally or in writing to Community First or health plan subcontractors by a Member or authorized representative, about any matter related to Community First other than an action as provided by 42 C.F.R. §438.400. Possible subjects for complaints include but are not limited to the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights. If the Member wishes to file a complaint, Community First is here to help. Please direct them to call Member Services at (210) 358-6060 or toll-free at 800-434-2347.

Members may file a complaint with Community First at any time. Members may contact Community First Member Services to request assistance in filing a complaint. We will mail a letter to the complainant within 5 days, to inform them that we have received their complaint. Then we will mail a letter with our decision within 30 days.

If a Member is not satisfied with the resolution of the complaint, after they have used the Community First Health Plans complaint process, they may file a complaint with the Health and Human Services Commission (HHSC), by calling 1-866-566-8989. If the member would like to file a complaint in writing, it may be addressed to

**Texas Health and Human Services Commission  
Health Plan Operations, H-320  
PO Box 85200  
Austin, Texas 78708-5200  
ATTN: Resolution Services**

### **B. Member Appeals**

A member has a right to request an appeal for denial of payment for services in whole or in part. The member may be required to pay cost of services furnished while appeal is pending.

If a member is not satisfied with the outcome of an action by Community First Health Plans, they can appeal the decision. To do so, the member or their authorized representative must file a request for appeal within 30 days from Community First Health Plans' notice of action.

However, to ensure continuity of currently authorized services, they must file the appeal on or before the later of 10 days following the Community First Health Plans mailing of the notice of action or the intended effective date of the proposed action.

Community First Health Plans Member Services can assist when a STAR member files an appeal.

The appeal must be made in writing to Community First Health Plans at the address below:

**Resolution Unit  
Community First Health Plans  
12238 Silicon Drive, Suite 100  
San Antonio, Texas 78249**

A member or their authorized representative may also call 800-434-2347 to request an Appeals Form or assistance with understanding Community First Health Plans' appeal process. If an oral appeal is first initiated, it should be followed up with a written and signed appeal sent to the Health Services Management Resolution Unit, unless an expedited appeal is requested.

The Health Services Management Resolution Unit at Community First Health Plans will send the member an acknowledgement of the appeal within 5 days and a decision on the appeal within 30 days.

Community First Health Plans will complete the investigation and resolution of an expedited appeal in accordance with the immediacy of the case and notify the member or their authorized representative of the outcome within three (3) business days.

The timeframe may be extended up to 14 calendar days if member requests an extension; or the HMO shows that there is a need for additional information and how the delay is in the Member's interest.

The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

### **C. Member Expedited Appeal**

Community First Health Plans STAR members may request an expedited appeal if the STAR Member is not satisfied with the denial of a benefit limitation for a covered benefit. . Community First Health Plans STAR members 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

a denial of emergency care, a life threatening condition or an inpatient hospitalization.

Community First Health Plans Member Services can assist when a STAR member files 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.

The timeframe may be extended up to 14 calendar days if member requests an extension; or the HMO shows that there is a need for additional information and how the delay is in the Member's interest.

Community First Health Plans will send the member a letter to acknowledge receipt of appeal request within 5 days and complete the entire appeal process within 30 days.

#### **D. State Fair Hearing Information**

##### **Can A Member ask for a State Fair Hearing?**

If a member of Community First Health Plans, disagrees with the health plan's decision, the member has the right to ask for a fair hearing. The member may name someone to represent the member by writing a letter to Community First Health Plans informing them the name of the person representing the member. A provider may be your representative. The member or the member's representative must ask for the fair hearing within 90 days of the date on the Community First's letter that tells the member of the decision being challenging. If the member does not ask for the fair hearing within 90 days, the member may lose their right to a fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to the health plan at:

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

Or, call Community First Health Plans at 800-434-2347.

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

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

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

## **XI. MEMBER ELIGIBILITY AND ADDED BENEFITS**

### **A. Eligibility**

The Health and Human Services Commission (HHSC) is responsible for determining member eligibility.

#### **1. Persons Eligible to Participate in the STAR Program**

- a. **Mandatory enrollment** in one of the STAR Managed Care programs is required for persons qualifying under TANF and TANF-related guidelines. **(Exhibit 2)**
- b. **Voluntary enrollment** in one of the STAR Managed Care programs is allowed for persons who are Blind and Disabled and are not Medicare eligible (Categories 03 and 04). **(Exhibit 2)**

#### **2. Persons Not Eligible to Participate in STAR Managed Care**

- a. Persons who are Medicare eligible
- b. Nursing Home Residents
- c. Aliens and Foster Children
- d. Persons in the Medically Needy Program

### **B. Verifying Eligibility**

Each STAR Member is issued a Texas Benefits Medicaid and a Health Plan (i.e., Community First Health Plans) ID Card. We instruct the STAR Members to present both ID Cards when requesting medical services.

The Community First Health Plans ID Card **(Exhibit 4)** shows important Member information, such as, Community First Health Plans telephone numbers and the member's assigned PCP. Providers may contact Community First Health Plans by telephone to verify Member eligibility by calling (210) 358-6060.

A member who appears on a PCP's monthly Member Roster is considered to be an existing member from the first month that he/she appears on the roster and therefore cannot be refused services while assigned to that PCP.

At the time of the visit ask the Member to show both forms of ID. The Texas Benefits Medicaid Card will verify coverage for the current month only, and will also identify if the holder is a STAR Member, and name of the Plan. The Community First Health Plans ID Card and Texas Benefits Medicaid Card do not guarantee eligibility for coverage. Another way to verify eligibility is through TMHP's Automated Inquiry System (AIS) or TxMedConnect or Community First Provider Web Portal Provider must document this verification in their records and treat the client as usual.

### **Temporary ID (Form H1027-A):**

Form 1027-A is acceptable as evidence of eligibility during the eligibility period of the letter unless the letter contains limitations that effect eligibility for the intended services. Providers must accept either Texas Benefits Medicaid Card or Form 1027-A as valid proof of eligibility. If the Member is not eligible for medical assistance or certain benefits, the member is treated as a private pay patient.

Although the temporary Medicaid Eligibility Verification Form 1027-A (**Exhibit 26**) identifies eligible clients when the client Texas Benefits Medicaid Card is lost or has not yet been issued, Form 1027-A does not indicate periodic eligibility for medical checkup services. Providers should call the TMHP Contact Center at 800-925-9126 or check the TMHP website, [www.tmhp.com](http://www.tmhp.com), to verify a client's periodic eligibility for medical checkup services.

### **C. Benefits**

Community First Health Plans must provide Covered Services as described in the most recent *Texas Medicaid Provider Procedures Manual* (Provider Procedures Manual), the Texas Health Steps Manual (a supplement to the Provider Procedures Manual), and in all Texas Medicaid Bulletins, which update the Provider Procedures Manual except for those services identified as non-capitated services. Covered Services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

#### **The following is a list of Covered Services:**

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services for children (under age 21)
  - Inpatient and outpatient chemical dependency services
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing center services if available within the service area
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services

- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

In addition to the standard covered benefits, Community First Health Plans STAR Members are eligible for the following benefits:

- Annual Adult Well Checks
- Removal of the Spell of Illness Limitation
- Unlimited Prescriptions for Adults
- \$200,000 annual limit on inpatient services does not apply for STAR members

#### **D. Value-Added Services**

- Community First Health Plans' providers are already knowledgeable about these value-added services and the Provider Newsletter is used to highlight the services prior to implementation. STAR members are informed through the HHSC health plan comparison charts. These services will also appear in the STAR member handbook.

<b>Value-added Service</b>	<b>Description of Value-added Service and Members eligible to receive the services</b>	<b>Limitations or Restrictions</b>	<b>Provider(s) responsible for providing this service</b>
24-hour Nurse Advice Line	A nurse line is available to all members to help steer urgent care cases to the appropriate facilities and assist with general questions.	There are no limitations or restrictions that apply.	NurseLink, a division of the University Health System.
Bus Tokens	Bus Tokens for medical appointments and health education classes are provided to Members who request them. Bus tokens are carried by Community First Health Plans Community Outreach staff to give to members when the MTP is not available. Tokens are also available by mail to allow for more immediate transportation to medical appointments, pharmacies, and	Bus tokens are distributed only to adult members or adult guardians of members under 18.	VIA Metropolitan Transit, San Antonio's public transportation system.



	education classes when the state transportation program is not available to the member.		
<b>Asthma Kits</b>	Members with asthma are provided with an Asthma Kit which contains a peak flow meter and OptiChamber. <b>STAR Members in Bexar Service Area.</b>  Asthma Kit is not included in Encounter Data, however, utilization is included in the Financial Statistical Report	Members may request no more than one Asthma Kit.  No Cost to the Member	Community First Health Plans' Preventive Health and Disease Management staff
Gift Cards	Five dollar (\$5) gift cards from HEB are available for health-related items for pregnant members, members with asthma, and members with diabetes for the enrollment into the disease management / population management programs and another for participation in the educational sessions. <b>STAR Members in the Bexar Service Area.</b> Utilization of the Value-added Service is not included in Encounter Data however; utilization is included in the Financial Statistical Report.	Gift card restrictions include no beer, wine, alcohol, or cigarettes may be purchased.	Community First Health Plans' Preventive Health and Disease Management staff
Incentive for completion of post-discharge follow-up appointment	Five dollar (\$5) gift cards from HEB are available for completion of post-discharge follow-up appointment within seven days of discharge from an acute inpatient facility.	Gift card restrictions include no beer, wine, alcohol, or cigarettes may be purchased..	Behavioral Health Case Manager
ER Reduction	Distributed to newly identified Medicaid members age 2 years and younger as soon as they are active with the health plan. Kit contains a thermometer and parent First Aid Kit. <b>STAR Members in Bexar Service Area.</b> Emergency Kit is not included in Encounter Data; however, utilization is included in the Financial Statistical Report.	Members 2 years of age or younger receive one ER Reduction kit per family	Community First Health Plans' Preventive Health and Disease Management staff
Smoking Cessation	Community First Health Plans has contracted for the Tobacco Cessation Program developed by the University Health system. Currently, the referrals from Community First Health Plans are coming from the new member postcards; special health care needs, asthma, diabetes and prenatal programs; members and local physicians. Members who smoke are asked if they are interested in quitting. Members who indicate an interest in quitting are referred to the Tobacco Cessation program. When the Community First Health Plans staff receives the referrals and verifies eligibility, the referrals are forwarded to the Tobacco	There are no age limitations to this program.  No cost to the member	University Family Health Centers – Southeast, North and Downtown

	<p>Cessation staff by fax. The Tobacco Cessation staff receives the referrals and contact with the member is made. Once contact is made with the member, if the member agrees, staff will proceed to enroll the member into program.</p> <p>The program is made up of 4 one-on-one or group sessions. The visits are all held one week apart. A member is asked if they have a prescription for a cessation aid (Zyban) if they do not, then a prescription is requested from their provider.</p> <p>The sessions cover:</p> <ul style="list-style-type: none"> <li>• "Decision is Yours"</li> <li>• "When Smokers Quit"</li> <li>• "Why Do I Smoke"</li> <li>• "Smoke Free Contract"</li> <li>• "Personal Log Form"</li> <li>• "Personal Quit calendar"</li> <li>• "Trigger Plan for Non-Smokers"</li> <li>• "My Plan to Deal with Triggers"</li> <li>• "The 4 Ds for Living Through a Craving"</li> <li>• "The Healthy Plate"</li> <li>• "An Ex-Smoker's Guide to Weight Control"</li> <li>• "Coping with Stress"</li> </ul> <p>After the "quit" date, there are 6 follow-up visits scheduled. The follow up visits are conducted via telephone.</p> <p><b>STAR Members in the Bexar Service Area.</b></p> <p>Services which are billed using CPT codes S9453 – smoking cessation will be submitted as medical encounter data and will be reported with the financial arrangement code 11 "Value Added Services paid through the claims processing system"</p>		
Additional Vision Benefit	\$125.00 allowance on prescription lenses and frames	Medicaid recipients under age 21	OptiCare providers
Discount Pharmacy Benefit	15-40% discount on prescriptions for other family members	Community First Health Plans Medicaid recipients	Medicaid contracted pharmacies
Sport and Back to School Physicals	One sports physical and one back to school physical may be provided once every twelve months.	Allowable for any Non-SSI Medicaid recipients age 19 years of age or younger.	Primary Care Providers (PCP's) or an In-plan Provider who also renders Texas Health Steps visits.

## **E. Involuntary Disenrollment**

Community First Health Plans has a limited right to request dis-enrollment of STAR Members. The STAR Member may request the right to appeal such decision. The PCP will be responsible for directing the STAR Member's care until the dis-enrollment is made. Request to dis-enroll a Community First Health Plans STAR Member is acceptable under the following circumstances:

- STAR Member misuses or lends his/her Community First Health Plans membership ID Card to another person to obtain services.
- The STAR Member is disruptive, unruly, threatening or uncooperative to the extent that the STAR Member seriously impairs Community First Health Plan's or a provider's ability to service the STAR Member. However, this only occurs if the STAR Member's behavior is not due to a physical or behavioral health condition.
- The STAR 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.

## **XII. MEMBER RIGHTS AND RESPONSIBILITIES**

### **A. Member Rights:**

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
  - a. Be treated fairly and with respect.
  - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
  - a. Be told how to choose and change your health plan and your primary care provider.
  - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
  - c. Change your primary care provider.
  - d. Change your health plan without penalty.
  - e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
  - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated, regardless of cost or what your benefits cover.
  - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - a. Work as part of a team with your provider in deciding what health care is best for you.
  - b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:

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

**B. Member Responsibilities:**

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

- a. Learn and understand your rights under the Medicaid program.
  - b. Ask questions if you do not understand your rights.
  - c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
  - a. Learn and follow your health plan's rules and Medicaid rules.
  - b. Choose your health plan and a primary care provider quickly.
  - c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
  - d. Keep your scheduled appointments.
  - e. Cancel appointments in advance when you cannot keep them.
  - f. Always contact your primary care provider first for your non-emergency medical needs.
  - g. Be sure you have approval from your primary care provider before going to a specialist.
  - h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
  - a. Tell your primary care provider about your health.
  - b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
  - c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
  - a. Work as a team with your provider in deciding what health care is best for you.
  - b. Understand how the things you do can affect your health.
  - c. Do the best you can to stay healthy.
  - d. Treat providers and staff with respect.
  - e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U. S. Department of Health and Human Services (HHS) toll free at 1800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at [www.hhs.gov/cor](http://www.hhs.gov/cor).

### **C. Can a Member ask for a State Fair Hearing?**

If a Member, as a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a fair hearing. The Member may name someone to represent him or her by writing a letter to Community First Health Plans telling Community First Health Plans the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the fair hearing within 90 days of the date on Community First Health Plans' letter that tells of the decision being challenged. If the Member does not ask for the fair hearing within 90 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member's representative should either send a letter to Community First Health Plans at 12238 Silicon Drive, Suite 100, San Antonio TX 78249 or call 800-434-2347.

If the Member asks for a fair hearing within 10 days from the time the Member gets the hearing notice from Community First Health Plans, the Member has the right to keep getting any service Community First Health Plans denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

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

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

### **D. Self Referrals**

STAR Members may self refer for the following services:

- Emergency Care
- Texas Health Steps Dental
- Family Planning Services
- Obstetrical and/or Gynecological Services
- School Health & Related Service (SHARS)
- MHMR Services
- Behavioral Health
- Case management – Children and Pregnant Women (CPW), Early

Childhood Intervention (ECI), Texas Health Steps Case Management

- School Based Health Clinics Services
- 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 PCP is encouraged to provide or coordinate referrals for the services shown above.

#### **E. Member's Right to Designate an OB/Gyn**

Community First Health Plans does not limit your selection of an OB/Gyn to your PCP's network.

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

- One well-woman checkup per year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

#### **F. Fraud Reporting**

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

##### **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 ID
- Using someone else's Medicaid 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 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 Community First Health Plans:
  - Community First Health Plans  
12238 Silicon Drive, Suite 100  
San Antonio, TX 78249
  - Health Plan Toll Free Phone Number at 800-434-2347
  - Call Community First Health Plan's Fraud Hotline at (210) 358-6332
  - Submit a referral on the Community First Health Plan web portal

**To report waste, abuse or fraud, gather as much information as possible. Remember to gather as much information as possible. Such as:**

- Name, Address and phone number of the Provider
- 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. ...)
- Contact information of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

**When reporting abuse 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

### **Special Investigations Unit**

In response to rules enacted on May 13, 2004, by the State of Texas under Title 1, Chapter 353, a Special Investigation Unit, managed under Community First Health Plan's Coding and Compliance Department (hereinafter referred to as "Coding and Compliance") has been established by Community First Health Plans. 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 Special Investigation 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.

**Special emphasis is placed on defining specific acts of fraud, waste and abuse.**

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

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

**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.

To report providers, use this address:

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

To report clients, use this address:

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

## **Procedures for Audit and Investigation:**

### **Audits**

Providers agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the provider's contract and any records, books, documents, and papers that are related to the Network Provider contract and/or the provider's performance of its responsibilities under this contract:

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;
3. MCO Program personnel from HHSC or its designee;

4. The Office of Inspector General;
5. The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
7. The Office of the State Auditor of Texas or its designee;
8. A State or Federal law enforcement agency;
9. A special or general investigating committee of the Texas Legislature or its designee; and
10. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC

Providers must provide access wherever it maintains such records, books, documents, and papers. Providers 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:

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 the said 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 at no cost

Coding and Compliance performs audits to monitor compliance and assist in detecting and identifying possible Medicaid program violations and possible Waste, Abuse, and Fraud overpayments through:

- Data matching – procedures, treatments, supplies, tests, and other services as well as diagnosis billed are compared for reasonableness using available sources including the American Medical Association (AMA), Centers for Medicare/Medicaid Services. Comparisons include age, gender, and specialty when applicable.
- Analysis – inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of providers' activities lists outliers based on particular specialty and across all specialties and includes procedures, modifiers, and diagnosis. Pharmacy data may be reviewed if

provided in usable format by HHSC.

- Trending and Statistical Activities – Coding and Compliance uses EDI Watch software to build provider profiles that show trends and patterns of submissions based on key claim elements and includes providers' patient activities. Statistical analysis shows provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

## **Monitoring**

Coding and Compliance monitors patterns for providers, subcontractors and facilities submitting claims. The monitor lists outliers based on claims submissions and utilization. Any provider that is flagged for certain payment patterns is also examined for other flags to paint an overall profile. Recipients with flags will be examined for other flags as well and to evaluate patient-provider relationships.

## **Hotline**

Community First Health Plans maintains an anti-fraud hotline, at (210) 358-6332 to allow reporting of potential or suspected violations of waste, abuse and fraud by members, providers and employees. A recording device is utilized to capture calls. Messages left on the recording device and are answered by Coding and Compliance personnel within two business days. The hotline number is printed on appropriate member and provider communications and published on the Community First Health Plans web site. The hotline number is also included in Community First Health Plans provider and member handbooks.

Coding and Compliance maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

## **Random Payment Review**

The profiling and statistical analysis is performed on random selection of claims submitted by providers for reimbursement by varying criteria to detect potential overpayment. The queries include a random function to create the reports on different blocks of data and apply them toward flagged claims.

## **Edits**

Community First Health Plans utilizes claim-editing software to prevent payment for fraudulent or abusive claims. It is an established and widely used clinically based auditing software system that verifies the coding accuracy of professional service claims.

These edits include specific elements of a claim such as procedure, modifier, diagnosis, age, gender, or dosage. Community First Health Plans applies the edits through AMISYS, Community First Health Plans' claims adjudication system. The edits are commonly accepted and verifiable filters including the national guidelines published by CMS, CCI, OIG and AMA.

### **Routine Validation**

Community First Health Plans provides our vendor, EDI Watch with three years of claims data. EDI Watch processes the electronic claims data on a quarterly basis. EDI Watch supplies a data load to Coding and Compliance, which applies edits, flags, fraud rules, and build routine activity profiles. These routine validations produce:

- Summary Of Findings – A high level of flags and potential overpayment across all claims to identify major areas of concern.
- Triage Reports – List of providers that are in the high percentile of flags and/or utilizations on which Community First Health Plans can focus.
- Detail Reports – Provide details supporting the profile activities of a provider or patient.

### **Procedures for Detecting Possible Acts of Waste, Abuse or Fraud by Recipients**

Coding and Compliance utilizes software flags for detecting possible acts of waste, abuse or fraud by Community First Health Plans recipients. Flags include:

- Treatments and procedures that appear to be duplicative, excessive or contraindicated by more than one provider, i.e., same patient, same date-of-service, same procedure code.
- Medications that appear to be prescribed by more than one provider, i.e., same patient, same date-of-service, and same NDC code.
- Recipients that appear to receive excessive medications higher than average dosage for the medication.
- Compare the Primary Care Provider (PCP) relationship code to the recipient to evaluate if other providers and not the PCP are treating the recipient for the same diagnosis.
- Identify recipients with higher than average emergency room visits with a non-emergent diagnosis.

Coding and Compliance utilizes Community First Health Plans specialty codes to identify psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists. The software flags can detect by specialty code possible overuse and/or abuse of psychotropic and /or controlled medications by recipients who are treated by two or more physicians at least monthly.

Coding and Compliance requests medical records for the recipients in question if claim data review does not clearly determine evidence of overpayment. Upon the receipt of the records from the provider, Coding and Compliance reviews the documentation for appropriateness and reports to the HHSC-OIG if necessary.

### **Procedures for Determining General Overpayments**

**The following types of reviews are performed in the determination of overpayments:**

- Compliance audits
- Monitoring of service patterns
- Random payment review of claims
- Routine validation of claim payments
- Pre-payment review
- Review of medical records
- Focused reviews
- Review of claim edits or other evaluation techniques
- Itemized hospital bill reviews
- DRG Reviews

**Findings that are considered general overpayments include the following:**

- Billing errors
- Insufficient documentation to support billed charges
- Inappropriate use of modifiers
- Incorrect billing provider
- Duplicates
- Billing for a different authorized services
- Data matching of diagnosis and procedure codes
- Unbundling of services, procedures and/or supplies
- Claim processing errors

### **Reporting and Returning of Overpayments**

Patient Protection and Affordable Care Act ("PPACA §6402(a)") signed by President Obama on March 23, 2010 requires that Medicaid overpayments be "reported and returned" **within 60 days** after they are "identified". When a provider has

“identified” an overpayment, the provider has the responsibility to report and return the overpayment to Community First Health Plans and notify Community First Health Plans in writing of the reason for the overpayment.

The failure to timely report and/or return any Medicaid overpayments, identified by either providers or Community First Health Plans, can have severe consequences, including termination from the Provider Network, potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs. “PPACA §6402(d)(2), and 6502”.

Community First Health Plans will notify providers of any identified overpayments within 60 calendar days of the findings. Refunds are due within 60 calendar days of the refund request. Refunds not received or appealed in a timely manner may be recouped. Community First Health Plans may analyze claim data or validate services for improper payments/overpayments up to a maximum of a three (3) year period from the date of the received claim(s). “PPACA §6411”.

**Coding and Compliance has established the following process regarding recovery of overpayments discovered through reviews and audits excluding fraud investigations.**

**Medicaid program general overpayments will be processed in the following manner:**

- Notification of overpayments may occur after the completion of an audit, medical record review, data validation, monitoring activities and/or appeals
- Be in writing and include the specific claims and amounts for which a refund is due.
- Provide the basis and specific reasons for the request for refund.
- Include notice of the physician's or provider's right to appeal.
- Describe the method and due date by which the refund will occur.
- Describe actions that will occur if overpayment is not refunded.

**Medicaid program overpayment appeal process:**

- A physician or provider may appeal a request for refund by providing written notice of disagreement of the refund request not later than 45 days after receipt of overpayment notice. Upon receipt of written notice, Coding and Compliance shall begin the appeal process as provided in the contract with the physician or provider.

- A refund will not be recouped until the later of the 45th day after overpayment notification or provider has made arrangements in writing for payment with Coding and Compliance prior to the 45<sup>th</sup> day overpayment notification
- The appeal process does not apply in cases of fraud or a material misrepresentation. Fraud is considered and noted as intentional after a practitioner or provider has been previously educated in writing or in person by Community First Health Plans regarding the same or similar audit, review or investigational findings or there is reasonable clear evidence of intent.

**Non Voluntary Repayment of Overpayments Will Result in any or all of the Following Actions:**

- Recoupment of overpayment from future claims
- Payment hold
- Termination from the Community First Health Plans Network
- Referral to the appropriate regulatory agency
- Exclusion from Medicare/Medicaid

**Fraud, Waste and Abuse Education**

Recipients and providers are offered fraud, waste and abuse education through a variety of avenues such as Community First Health Plans web site, member and provider newsletters, provider manuals, and member handbook. The information contained in the material includes the definitions and examples of fraud, waste and abuse and how to report fraud, waste and abuse.

Provider newsletters also offer compliant coding and medical record documentation tips.

Consistent with Section 6032 of the Deficit Reduction Act of 2005, Community First Health Plans has established guidance to educate recipients, providers, employees, contractors and agents regarding the reporting of fraud, waste or abuse. For clarification purposes, contractors and agents are defined by CMS as “one which, or one who, on behalf of Community First Health Plans, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care”.

**Failure to respond to Medical Records request**

Failure to submit medical records as requested will result in recoupment.

Additionally, in accordance with 1 Texas Administration Code (TAC), §§ 371.1617(2), 371.1643 and 371.1649 sanctions may be imposed against you if you fail to provide the information as requested. Possible sanction actions may include, but not limited to, vendor hold and/or exclusion from participation as a provider in the Texas Medicaid



program, until the matter is resolved. Additionally, payments for services for which records are not produced may be recovered.

### **XIII. ENCOUNTER DATA, BILLING AND CLAIMS ADMINISTRATION**

#### **A. Where to Send Claims/Encounter Data**

##### **Paper Claims**

Submit claims to:

Community First Health Plans Health Plans, Inc.  
P. O. Box 853927  
Richardson TX 75085-3927

or

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

##### **Electronic Claims - Availity**

Community First Health Plans accepts electronically submitted claims through Availity. Claims filed electronically must be files using the 837P or 837I format. Billing instructions can be found at the Availity website. Electronically submitted claims must be transmitted through Availity using Community First Health Plans' Payor Identification as indicated below:

Community First Health Plans Payor ID: COMMF  
Community First Health Plans Receiver Type: F

##### **Electronic Claims – TMHP.COM**

**Providers may submit electronic claims to Community First Health Plans via TMHP's web site.**

#### **B. Claim Form to Use**

Physician and other health care providers must file paper claims on a CMS-1500 (**Exhibit 19**). Federally Qualified Health Centers (FQHC) can file on either a CMS 1500 or a UB 04. **See Exhibit 19 for a sample claim form and complete instructions.**

Community First Health Plans should be billed your normal (usual and customary billed) charges only. We will make the necessary adjustments, and will show the adjustments made on the Explanation of Payment (EOP) sent to you with your reimbursement check.

Hospitals, Rural Health Clinics (RHC), and Other Facilities must bill on a UB 04 (Exhibit 20). See Exhibit 20 for a sample claim form and complete instructions.

Note: Only claims including all required information will be considered clean claims.

Note: Newborn claims should be submitted with all of the required elements above. However, if a Medicaid number for the newborn is unavailable then utilize the mother's Medicaid ID # with the correct date of birth for the newborn.

### **C. Monthly Capitation Services**

**The following is a list of Capitated Services that Community First Health Plans is responsible for providing to STAR Members:**

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services for children (under age 21)
  - Inpatient and outpatient chemical dependency services.
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing center services if available within the service area
- Chiropractic services
- Dialysis
- Medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays

- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

Providers may call Community First Health Plans with questions about what services are included in monthly capitation.

#### **D. Emergency Service 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 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, 24hours 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.

PCPs should become actively involved in educating STAR Members regarding the appropriate use of the emergency room and other emergency services. PCPs should notify Community First Health Plans of any Member who may need further education by calling the Member Services Department at Community First Health Plans.

If a Member has an emergent condition, the emergency room must treat the Member until the condition is stabilized or until the client can be admitted or transferred. Once the member is stabilized, the Emergency Room staff must notify Community First Health Plans to arrange for medically necessary hospital admission or follow-up care with the Member's PCP.

#### **E. Pharmacy Claims**

- 30-day Clean Claim payment.
- 18-day Clean Claim payment for electronic pharmacy claim submission.
- Claim submission requirement (within 95 days)
- Approved claim forms

#### **F. No Co-payments for Medicaid Managed Care Members**

In Medicaid Managed Care programs, Members may assume a responsible role in achieving their personal health care by choosing a PCP, actively participating with their PCP to access preventive, primary care services. This collaborative approach to health care delivery does not require or allow the collection of a co-payment from the STAR Member.

#### **G. 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:

- Failure to submit a claim, including claims not received by Community First Health Plans.
- Failure to submit a claim to Community First Health Plans for initial processing within the 95 day filing deadline.
- Failure to submit a corrected claim within the 120 day filing re-submission period.
- Failure to appeal a claim within the 120 –day appeal period.

#### **Payment for Services**

Provider is prohibited from billing or collecting any amount from a Medicaid Member for “health care services” rendered pursuant to the Provider contract. Federal and state laws impose severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service. The Provider understands and agrees that HHSC is not liable or responsible for payment of Covered Services rendered pursuant to the Provider contract.

## **H. Time Limit for Submission of Claims**

Providers are required to submit claims to Community First Health Plans ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Community First Health Plan’s Claims Customer Service Department at **(210) 358-6200**.

### **Proof of Timely Filing**

Community First Health Plans accepts the following as proof of timely filing:

- ✓ Returned receipt (Certified Mail)
- ✓ Electronic confirmation from Community First Health Plans vendor
- ✓ Receipt of claim log signed by Community First Health Plans employee
- ✓ Fax confirmation

### **Claims Submission**

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 statute or regulation in a shorter timeframe.

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 change if Community First Health Plans is unable to provide 30 days’ notice, Community First Health Plans must give providers a 30 day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

Community First Health Plans requests that if you are submitting paper claims the following steps should be followed to expedite payment:

- Use 10x13 inch envelopes; send multiple claims in one envelope
- Do not staple, paper clip or fold claim forms or attachments
- Do not use red ink
- Whenever possible generate your claims on a computer or typewriter (handwritten claims are difficult to read and scan)

If you would like information on submitting your claims electronically, contact Availity our vendor for electronic filing at (972-766-5480). Our payor ID number is COMMF. If you need additional information on electronic filing contact your network management representative.

1. Community First Health Plans will adjudicate all clean claims **(Exhibits 19 and 20)** within thirty (30) days from the date Community First Health Plans receives the clean claim(s).
2. Community First Health Plans will notify providers within thirty (30) days from the date we receive the claim(s), if we will deny or pend the claim(s) and the reason(s) for the denial.
3. Community First Health Plans will pay providers interest on any clean claim(s) we do not adjudicate within thirty (30) days from the date Community First Health Plans receives the clean claim(s). Community First Health Plans will pay the interest at a rate of 1.5% per month (18% annually) for each month we do not adjudicate within 30 days.

#### **I. Claims Payment and Payment Methodology:**

The Provider understands and agrees that HHSC is not liable or responsible for Payment for Covered Services rendered pursuant to the Providers Contract

Community First Health Plans will process all provider claims and pay all claims for Medically Necessary Covered Services that are filed within the time frames and are clean claims. All provider claims that are clean and payable claims must be paid within thirty (30) days from the date of the claim receipt.

Providers are required to submit claims to Community First Health Plans ninety-five (95) days from the date of service. Claims received after the filing date will be denied payment. Questions regarding claims should be directed to Community First Health Plan's Claims Customer Service Department at **(210) 358-6200**.

Unless otherwise specified in the Professional Provider Agreement, the payment methodology applicable to the provider is:

One hundred percent (100%) of the current State of Texas Medicaid Fee Schedule, as may be amended from time to time.

Texas Medicaid Fee Schedule is available on [www.thmp.com](http://www.thmp.com) and or calling 800-925-9126

Program Violations:

Arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G. *Network*.

**Supervised Providers:**

Providers must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.

**J. EOP, Duplicate Checks and Cancelled Check Requests**

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

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

Community First will provide the first request for an additional EOP at no charge. Any requests beyond the first request will be assessed a charge of \$15.00 per EOP and \$20.00 per check. The request for a copy of the EOP and/or check must be submitted in writing along with the appropriate fee. The request must include the date of the EOP, the name of provider, and date of the check. Send the request to:

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

**K. Special Billing**

**Claim Hints:**

- The following are to be used for newborns: • If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child. • Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. *Always* use "boy" or "girl" first and then the mother's full



name. An exact match must be submitted for the claim to process. • Do not use “NBM” for newborn male or “NBF” for newborn female.

- The name of your claim should be the same name as it appears on the Texas Benefits Medicaid Card.
- Make sure the sex of the member listed on the claim is accurate.

## **L. Billing and Claims Administration**

### **Coordination of Benefits**

A third party may cover some STAR Members (i.e., auto liability, disability, or workers’ compensation). In situations where a STAR Member has other insurance, the other insurance carrier will be the primary payor. Providers must bill the third party insurance first, and then attach a copy of the Explanation of Benefits (EOB) statement received from the third party insurance to the claim when filing with Community First Health Plans for reimbursement. Providers must file claims to Community First Health Plans within ninety-five (95) days of the third party insurance EOB. As a payor for Medicaid services, Community First Health Plans will act as the payor of last resort. Community First Health Plans will deny payment for claims that do not include proof of prior filing with the STAR Member’s third party insurance. If a STAR Member indicates they do not have a third party insurance, instruct the Member to contact Community First Health Plans’ Member Services Department for assistance.

### **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.

### **Provider under Investigation**

Community First Health Plans will not pay STAR claims submitted for payment by a 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.

### **Explanation of Payment (EOP)**

You will receive an EOP (**Exhibit 22**). The EOP will include the following information:

- ✓ Amount billed;
- ✓ Allowed (contracted) amount;
- ✓ Other insurance payment;

- ✓ Total benefit paid to the provider.
- ✓ *All reasons for the denial if payment is not made*

### **Claims Reconsideration**

If you disagree with the manner in which the claim was adjudicated, send the corrected and/or letter with a copy of the EOP to the claims address listed at the beginning of this section.

### **Appeals of “For Cause” HMO Agreement 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 an 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 Plan’s 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 Texas Insurance Code, including at least one representative in the provider’s specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Community First Health Plans. The decision of the advisory review panel must be considered by Community First Health Plans but is not binding on Community First Health Plans. Community First Health Plans must provide to the affected provider, on request, a copy of the recommendation of the advisory review panel and the Community First Health Plans determination.

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.

Providers may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A “thing of value” means

any item of tangible or intangible property that has a monetary value of more than \$50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Community First Health Plans may terminate the provider's contract at any time for violation of this requirement.

### **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 request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to Community First Health Plans' Medical Director. You should include any explanation or other information with your request for reinstatement. The Community First Health Plans Medical Director will appoint a committee to review your request, and any information or explanation provided within thirty (30) days of receipt. The committee will recommend an initial decision to the Board of Directors either to terminate your membership and reaffirm your agreement, reaffirm with sanctions, or to revoke.

### **Decision**

Within ten (10) days of receiving the committee's recommendations, Community First Health Plans will, by special notice in registered or certified mail, inform you of Community First Health Plans' decision on your request for reinstatement. This decision will be final.

## **M. Claims Questions/Appeals**

Providers have the right to appeal the denial of a claim by Community First Health Plans. The Provider has **120 days** from the date of the most recent Community First Health Plans' EOP to appeal the denial. Community First Health Plans will not accept any appeal submitted after the appeal deadline or appeals older than 2 years. Providers may submit a Claim Appeal Submission Form (**Exhibit 24**), via mail to:

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

Or

Submit the appeal request electronically using Community First Health Plans' secure provider portal.

Please direct any claim questions regarding appeals to Community First Health Plan's Claims Department at **(210) 358-6200**.

#### **XIV. MEMBER ENROLLMENT AND DISENROLLMENT FROM COMMUNITY FIRST HEALTH PLANS**

##### **A. Enrollment**

Babies born to Medicaid eligible mothers who are enrolled in Community First Health Plans will be enrolled into Community First Health Plans for ninety (90) days following the date of birth. The mother of the newborn may change her newborn to another Plan during the first ninety (90) days, but may only do so through the enrollment broker.

##### **B. Automatic Re-enrollment**

Community First Health Plans STAR Members who are dis-enrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the same health plan with the same PCP. Temporary loss of eligibility is defined as a period of six (6) months or less. Member has the option to switch plans at this time

##### **C. Dis-enrollment**

HHSC must approve any request by Community First Health Plans for such disenrollment. The STAR Member may request the right to appeal such decision. The PCP will be responsible for directing the STAR Member's care until the disenrollment is made. Request to dis-enroll a Community First Health Plans STAR Member **is acceptable** under the following circumstances:

- STAR Member misuses or lends his/her Community First Health Plans membership ID Card to another person to obtain services.
- The STAR Member is disruptive, unruly, threatening or uncooperative to the extent that the STAR Member seriously impairs Community First Health Plans' or a provider's ability to service the STAR Member. However, this only occurs if the STAR Member's behavior is not due to a physical or behavioral health condition.
- The STAR 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.
- Member's disenrollment request from managed care will require medical documentation from the Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

Provider cannot take retaliatory action against member. Medical documentation is required when a member be dis-enrolled. HHSC makes the final disenrollment decision.

**D. STAR Member PCP Change**

If a STAR 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 will become effective the first day of the second month following the change request.

## **XV. SPECIAL ACCESS REQUIREMENTS**

### **A. General Transportation and Ambulance/Wheelchair Van**

The Medical Transportation Program (MTP) was created in 1975. MTP is funded with Title XIX and State funds, and provides STAR Members and their attendant's non-emergency transportation services via the most cost-effective mode to medical facilities and doctor offices for Medicaid Covered Services. Transportation may be provided by bus (with a bus token provided by MTP) ambulance or wheelchair van. This transportation is provided in the most cost-effective manner and at no cost to the Member. Individual STAR Members may use the service if they have a current Medicaid ID and no other means of transportation.

### **B. Interpreter/Translation Services**

Community First Member Services includes advocates who can speak to you in English or Spanish, or we can get an interpreter who speaks your language.

Community First Health Plans has interpretive services available for its STAR Members to ensure effective communication regarding treatment, medical history or health education. These interpretive services are available on an "on-call" basis. Our contracted interpretive services provide Community First Health Plans STAR 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 STAR Member, please contact Community First Health Plans' Member Services Department at (210) **358-6060**.

### **C. Community First Health Plans and Provider Coordination**

Community First Health Plans will make every effort to communicate with and coordinate the delivery of Covered Services with a STAR Member's PCP. Community First Health Plans will provide each PCP and his/her staff with a current Provider Manual and revisions within five days of becoming network participants. Provider orientations will be completed within 30 days of the PCP becoming a network participant. Additionally, routine office visits will be made by assigned Network Management staff to answer any questions or concerns and to review critical elements with the physician and his/her staff.

Community First Health Plans will operate a toll-free telephone line 800-434-2347 for Providers from 8:00 AM till 5:00 PM (CST), Monday through Friday. The Provider Hotline will be staffed with personnel who are knowledgeable about Covered Services for Medicaid, about NON-capitated Services, and general health plan operations to assist the provider.

**D. Reading/Grade Level Consideration**

Community First Health Plans prints all STAR Member materials in both English and Spanish at a 4th - 6th grade reading comprehension literacy level.

**E. Cultural Sensitivity**

Community First Health Plans recognizes the diversity of the population in the STAR Program and has programs to support a multi-cultural membership. We staff Community First Health Plans' Member Service Department with knowledgeable, bilingual (English/Spanish) Member Service Representatives to help STAR Members with questions.

**F. Children with Complex and Special Health Care Needs**

The PCP for a STAR Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all the PCP duties required as outlined in the Provider Manual and the Professional Provider Agreement and within the scope of the specialist's license. Any interested person may initiate the request (**Exhibit 25**) to Community First Health Plans for a specialist to serve as a STAR Member who is disabled, has a Special Health Care Needs, or Chronic or Complex Condition. Community First Health Plans shall handle the request as outlined in its policy (*Specialist Physician as Primary Care Physician, # 500.17*) which is in compliance with 28.TAC Part 1, Chapter 11, Subchapter J.



## **XVI. UTILIZATION MANAGEMENT**

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 STAR 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 STAR Member and the attending physician.**

**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.**

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:

- Accepting and returning our phone calls concerning our STAR Members;
- Providing Community First Health Plans with complete medical documentation to support any preauthorization requests
- Allowing us to review medical and billing records concerning care rendered to our STAR Members to validate delivery of care against claims data;
- Participating with us in discharge planning, disease management, and case management;
- Participating with our Community First Health Plans committee proceedings when appropriate.



## **XVII. PREVENTIVE HEALTH AND DISEASE MANAGEMENT**

STAR 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 collaborative relationship between our members and their health care providers, to create a supportive environment for the development and maintenance of healthy lifestyle behaviors.

### **Provider Referral**

Providers are encouraged to inform STAR Members about the health education services available through Community First Health Plans. When an education or social need is identified, one can refer a STAR Member to the Preventive Health and Disease Management Department one of four ways:

Mail in the Member Education Request Form (**Exhibit 14**) to:

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

Fax the Member Education Request Form to (210) 358-6199.

Contact a Community First Health Plans Health Educator at **(210) 358-6144**.

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

### **Health Education Services**

Health education is available through classes, educational mail outs and individualized outreach visits. Several initiatives been developed to educate STAR 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 STAR member satisfaction and retention. Program participation information is routinely mailed to the primary care physician for review and inclusion in the STAR member's medical record.



### **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 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.





## **Asthma Disease Management**

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

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

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

Minimal Risk	Send education literature bimonthly
Mild to Moderate Risk	Send education literature bimonthly Provide peak flow meter and OptiChamber kit Follow-up call / Recommend asthma class
Higher Risk	Send education literature 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.



*Community First Health Plans* **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 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, 76<sup>th</sup> 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:

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

Community First Health Plans 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.

### **Community First Health Plans New Member Assessment Program**

Outreach is initiated to each new STAR member, to detect health risk factors, potential participation in population-based initiatives or disease management programs and to assess barriers to care. Educational information and resource information is given to members, including social services resources. Common STAR member concerns include transportation, utilities and nutritional 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 STAR 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.