

Providers can request removal of members from panel

On occasion, it may be necessary for a PCP to discharge a member from his or her panel. Reasons for dismissing a patient may include:

- Inappropriate use of services or benefits.
- Threats of physical harm to a provider or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner that is not medically beneficial or medically necessary.
- Refusal to accept a treatment or procedure recommended by the provider, if such refusal is incompatible with the continuation of the patient-physician relationship.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice

or to accessing benefits under the managed care plan.

- Other behavior, which has resulted in serious disruption of the patient-physician relationship.

Prior to dismissing a patient, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately. Acceptable documentation could include notes in the medical record, an incident report, documentation of missed appointments, documentation of recommended treatment plan, or documentation of appointment reminders. Any other reasons for discharging a patient must be individually considered by the TCHP Medical Director.

Following unsuccessful attempts to improve the patient/physician relationship, the primary care physician may proceed with dismissing the patient from his or her panel. To do so, the primary

care physician must complete the "Physician Request for Removal of Member From Panel" form, which can be found in the "Provider Rights and Responsibilities" section of the TCHP Provider Manual.

This form, along with the supporting documentation described above, must be submitted to TCHP's Network Development Department. Network Development will coordinate discharging the member with the Member Services Department.

Upon receipt of a "Physician Request for Removal of Member From Panel" form, Member Services will send written notification to the member advising that a PCP reselection is necessary. The requesting PCP will be copied on this correspondence. The requesting PCP should continue to treat the member for thirty (30) days following TCHP's member correspondence.

Provider concerns and complaints are addressed

Texas Children's Health Plan is committed to providing excellent customer service to its providers. Any provider who feels TCHP is not meeting this goal should contact a Provider Relations representative for assistance.

Provider Relations, which is part of the Network Development Department, is the first resource for resolving concerns. By definition, a Provider Concern is a provider's administrative concern or inquiry, not placed on behalf of a member, regarding claims payment, accessibility, contract administration, TCHP staff members, plan administration, member services, or any TCHP process.

A Provider Concern is resolved by clearing up a misunderstanding or supplying appropriate information to the satisfaction of the provider. Provider Concerns do not include a provider's dissatisfaction or disagreement with an Adverse Determination. To review a Provider Concern with your Provider Relations representative, please contact the representative directly or call the Network Development Department at 832-824-2695.

On occasion, a Provider Concern may evolve into a Provider Complaint. A Provider Complaint is defined as a provider's dissatisfaction, not placed on behalf of a member, regarding *continued* claims disagreement following an appeal. Provider Complaints also include accessibility, contract administration, TCHP staff members, plan administration,

member services, or any TCHP process. Provider Complaints do not include a provider's dissatisfaction or disagreement with an Adverse Determination.

Provider Complaints can be submitted in writing to TCHP using the "Provider Complaint Form," located in the TCHP Provider Manual and on the TCHP Web site (www.texaschildrenshospital.org/healthplan).

How to file a Provider Complaint with TCHP

Print the "Provider Complaint Form" directly from the Web site or copy the form from the TCHP Provider Manual. Complete this form and mail or fax it to:

Attention: Network Development Department
 Texas Children's Health Plan
 P.O. Box 301011, MB-8301
 Houston, TX 77230-1011
 832-825-2194

The complaint will be investigated, and the Network Development Department will send a response within forty-five (45) days of receipt of all necessary information needed to complete the resolution.

Claims issues must be appealed prior to filing a Provider Complaint. Documentation related to the appeal must accompany your Complaint Form. Please keep in mind that claims are subject to a 180-day appeal and resubmission deadline.

Outpatient diagnostic services: refer in-network

TCHP offers a wide selection of providers for outpatient laboratory and imaging services. It is not necessary to complete a TCHP referral form for these services. Instead, providers are only asked to issue a requisition form as specified by the lab or imaging center.

When referring a patient for outpatient laboratory or radiology services, please remember to refer patients to in-network providers. In-network providers include:

Laboratory Providers:

- Clinical Pathology Laboratories, Inc.
- Dynacare Memorial Hermann Laboratory Services
- Quest Diagnostics, Inc. Clinical Laboratories
- LabCorp Laboratories

In addition, members can be referred to any in-network hospital for laboratory services.

Radiology Providers:

- Bay Area MRI
- Bear Creek MRI
- Cat Scan Centre
- Champions MRI
- Conroe Open MRI & Diagnostic
- Diagnostic Imaging Specialist, Inc.
- Diagnostic MRI, LLC
- East Side Imaging
- Express Mobil X-Ray, Inc.
- Fallbrook Open MRI, Inc.
- Fannin Street Imaging
- FemCare
- Fort Bend Imaging

- Gulf Coast Open MRI & Diagnostic Center
- Houston Medical Imaging, LLC
- Katy Open MRI
- Lakeside Open MRI & Diagnostic Center
- Normandy Open MRI
- Open MRI of Wharton
- Pars MRI
- River Oaks Imaging & Diagnostic - Clear Lake
- River Oaks Imaging & Diagnostic - Conroe
- River Oaks Imaging & Diagnostic - Humble
- River Oaks Imaging & Diagnostic - I-10
- River Oaks Imaging & Diagnostic - Medical Center
- River Oaks Imaging & Diagnostic - Memorial
- River Oaks Imaging & Diagnostic - Pasadena
- River Oaks Imaging & Diagnostic - Richmond
- River Oaks Imaging & Diagnostic - Sugar Land
- River Oaks Imaging & Diagnostic - Willowbrook
- Southwest MRI & Diagnostics
- Steeplechase Diagnostic Center
- Sugar Land MRI & Diagnostic
- The Woodlands MRI
- Tomball Open MRI
- Town & Country Open MRI & Diagnostic
- West Loop MRI & Diagnostic Center
- Woodstead MRI, Inc.

In addition, members can be referred to any in-network hospital for radiology services.

For additional details regarding in-network providers, please refer to the "Network of Providers" section of the TCHP

Enrollment Forms are acceptable for plan identification

Occasionally, new members do not receive their member identification cards prior to accessing care.

When this occurs, the member may present an Enrollment Form in lieu of a member identification card. Provider offices

should accept the Enrollment Form as plan identification.

In addition, eligibility can be verified by calling TCHP, using Fax Recall or using ePower.

Provider Relations representatives improve communication

Texas Children's Health Plan encourages positive communication with its participating providers. Each provider office has been designated a Provider Relations representative. The Provider Relations representative is available to assist with any issues that may arise regarding TCHP and has the ability to advocate between a provider's office and any department within TCHP.

TCHP Provider Relations representatives	Geographic territory	Phone number
Mike Banda	North, northwest	832-824-6974
Denise Blakeslee	North, northeast	832-824-6979
Denise Evans-Turner	South, southwest	832-824-2963
Lucie Lara	East	832-824-6890
Susie Mancias	West	832-824-6903
Roland Munguia	South	832-824-6855

Understand a STAR Medicaid member's rights and responsibilities

STAR members have a right to:

1. Respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that their medical records and discussions with their providers will be kept private and confidential.
2. A reasonable opportunity to choose a healthcare plan and primary care provider (the doctor or healthcare provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be informed of how to choose and change health plans and primary care provider.
 - b. Choose any health plan that is available in their area and choose a primary care provider from that plan.
 - c. Change their primary care provider.
 - d. Change health plans without penalty.
 - e. Be educated about how to change their health plan or their primary care provider.
3. Ask questions and get answers about anything they don't understand. That includes the right to:
 - a. Have their provider explain their healthcare needs to them and talk to them about the different ways their healthcare problems can be treated.
 - b. Be told why care or services were denied and not given.
4. Consent to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with their provider in deciding what healthcare is best for them.
 - b. Say yes or no to the care recommended by their provider.
5. Utilize each available complaint process through the managed care organization and through Medicaid, receive a timely response to complaints and receive a fair hearing. That includes the right to:
 - a. Make a complaint to their health plan or to the state Medicaid program about their healthcare, provider or health plan.
 - b. Get a timely answer to their complaint.
 - c. Request a fair hearing from the state Medicaid program about their complaint.
6. 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, seven days a week in order to obtain any needed emergency or urgent care.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a healthcare provider's office, including barrier-free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters

- e. include people who can speak in their native language, assist with a disability, or help them understand the information.
- e. Be given an explanation they can understand about their health plan rules, including the healthcare services they can get and how to get them.
7. Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they don't want to do or to punish them.

STAR members have a responsibility to:

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

Based upon Member Bill of Rights, adopted by Texas Health and Human Services Commission, contained in 1 TAC 353.201-353.203.

Know a CHIP member's rights and responsibilities

Children's Health Insurance Program (CHIP) members have a right to:

1. Get accurate, easy-to-understand information to help them make good choices about their child's health plan, doctors, hospitals and other providers.
 - Their health plan must tell them if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. They can't see all the doctors who are in their health plan. If their health plan uses "limited networks," they should check to see that their child's primary care provider and any specialist doctor they might like to see are part of the same "limited network."
 - They have a right to know how their doctors are paid. Some get a fixed payment no matter how often they visit. Others get paid based on the services they give to their child. They have a right to know what those payments are and how they work.
 - They have a right to know how the health plan decides whether a service is covered and/or medically necessary. They have the right to know about the people in the health plan who decide those things.
 - Their health plan may make you only use drugs from an approved list. This is called a "drug formulary" and they have the right to know which drugs are on it.
 - They have a right to know the names of the hospitals and other providers in their health plan and their addresses.
2. Pick from a list of healthcare providers that is large enough so that their child can get the right kind of care when their child needs it.
 - If their child is confirmed to have special healthcare needs or a disability, they may be able to use a specialist as their child's primary care provider. They can ask their health plan about this.
 - Children who are confirmed to have special healthcare needs or a disability have the right to special care.
 - If their child has special medical problems, and the doctor their child is seeing leaves their health plan, their child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. They can ask their plan about how this works.
 - If their health plan uses a drug formulary, and their child needs a drug that is not on the formulary, they may have the right to keep using that drug if their child's doctor believes it is necessary.
 - Their daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with her health plan. They can ask their plan how this works. Some plans may make her pick an OB/GYN before seeing that doctor without a referral.
3. Obtain emergency services when they need them if they reasonably believe their child's life is in danger, or that their child

- would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with their health plan. They may have to pay a few dollars depending on their income. This is called a "co-pay."
4. Take part in all the choices about their child's healthcare.
 5. Speak for their child in all treatment choices.
 6. Get a second opinion from another doctor in their health plan about what kind of treatment their child needs.
 7. Be treated with respect and kindness when they visit a doctor's office, go to the hospital or talk to their health plan.
 8. Be treated fairly by their health plan, doctors, hospitals and other providers.
 9. Talk to their child's doctors and other providers in private, and to have their child's medical records kept private. They have the right to look over and copy their child's medical records and to ask for changes to those records.
 10. A fair and quick process for solving problems with their health plan and the plan's doctors, hospitals and others who provide services to their child. If their health plan says it won't pay for a covered service or benefit that their child's doctor thinks is medically necessary, they have a right to have another group, outside the health plan, tell them if they think their doctor or the health plan was right.

CHIP members have a responsibility to:

1. Try to follow healthy habits, e.g., encourage their child to exercise, to stay away from tobacco and to eat a healthy diet.
2. Become involved in the doctor's decisions about their child's treatments.
3. Work together with their health plan's doctors and other providers to pick treatments for their child that they have all agreed upon.
4. Try to first resolve any disagreements with their health plan by using the health plan's complaint process.
5. Learn about what their health plan does and does not cover. Read their member handbook to understand how the rules work, and how they can try to change health plan choices that they don't like.
6. Show respect for other families and for the people who are trying to help their child.
7. Try to get to the doctor's office on time if they made an appointment for their child. If they can't keep the appointment, they should call and cancel it at least 24 hours prior to their appointment time.
8. Remember to pay their doctor and other providers what they owe them. Members should keep track of what they pay.
9. Report misuse of the CHIP program by healthcare providers, other CHIP members or CHIP health plans.
10. Treat providers and their staff with respect and courtesy. Members should not use abusive and threatening language and behavior.

Adopted by Texas Health and Human Services Commission.

Providers can file claims appeal or resubmission

If a provider feels that a claim has been processed incorrectly, the provider may file a claims appeal or resubmission within 180 days of the claim processing date to be eligible for payment.

Each appeal and resubmission should be resubmitted using the appeal or resubmission cover sheets located in the

“Compensation” section of the TCHP Provider Manual along with “proof of timely filing.” Acceptable proof of timely filing may be in the form of a health plan explanation of benefits (EOB) or other health plan correspondence. If filing claims electronically, please remember that a rejection report from an elec-

tronic claims vendor is not acceptable proof of timely filing.

If TCHP's vendor rejects the claim, providers will receive a cover letter and EDI claim copy from TCHP. The EDI claim copy documents the date of receipt and can be used to document proof of timely filing.

Complete an On Call Provider Agreement Form

Texas Children's Health Plan requires all primary care physicians to maintain 24 hours per day, seven days per week access to care. Such access may be provided by the physician or by a covering physician who agrees to accept the terms of the TCHP Provider Agreement.

Covering physicians can charge members for copayments, coinsurance and deductibles, but must not bill members for covered services. Additionally, on call providers must follow

all procedural requirements of the plan, including referral and authorization requirements.

Providers can designate call coverage arrangements by completing an On Call Provider Agreement Form. A copy of this form is included in the “Provider Responsibilities” section of the TCHP Provider Manual. If you have any questions on how to complete this form, please contact Provider Relations at 832-824-2695.

Panel closure policy and procedure is simple

At times, it may be necessary for a primary care physician to close his or her patient panel to new members to facilitate timely patient care. TCHP's policy and procedure for closing a patient panel is as follows:

- The PCP must send a written request to the Network Development Department at TCHP, providing 60 days advance

notice of the panel closure.

- The PCP must continue to accept new patients during this 60-day period. A PCP may not select an open or closed panel by product. Instead, a closed panel can be selected for all products within a business line (i.e. commercial products or Medicaid products).

- TCHP will note a physician's closed panel in the provider directory, which is distributed to members.

A PCP may reopen the patient panel to new members by submitting a written request to TCHP and providing 60 days advance notice.

Understand member's complaint and appeal process

When members are not satisfied with the care or service they are receiving, they have the right to make a complaint. To place a complaint, members can call Member Services at 832-824-2600. A Member Services representative will assist them. The representative will try to help them as much as possible, and then their complaint will be forwarded to the Quality Management Department. This department will send members a letter to let them know they have received their complaint.

The staff will investigate the problems members have reported and determine how they might be resolved. Members will receive a letter no later than 30 days after they place the complaint, telling them how the problem has been handled. If this does not satisfy them, there will be instructions in the letter about how members can appeal so that Texas Children's Health Plan will re-look at the problem and try to answer their concerns. TCHP takes all complaints seriously.





Texas Children's
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A Subsidiary of Texas Children's Hospital

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Provider News

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Updates made to CPT coding

In compliance with the new, standardized coding requirements for the Medicaid program, Texas Children's Health Plan (TCHP) has updated its claims payment system, effective Oct. 16, 2003.

Under the new requirements, providers should not bill Medicaid local codes for dates of service after Oct. 15, 2003. Beginning on Oct. 16, providers should bill CPT codes for services rendered to Medicaid members.

Preventive care visits, for instance, can be billed using the following codes:

- New patient: 99381, 99382, 99383, 99384, 99385

- Established patient: 99391, 99392, 99393, 99394, 99395

Modifiers should be applied to preventive care codes to indicate what type of practitioner provided the services. Modifiers should be applied to the visit code only, as was previously the case with preventive care visits using the Medicaid local codes.

Modifiers that are applied to immunization or administration codes are not valid. Valid modifiers for preventive care visits include: AM, SA, TD, U7, EP.

Request help for member non-compliance

Members are responsible for keeping scheduled appointments and calling to cancel appointments in advance in accordance with providers' office policies. Repeated failure to do so is considered "Patient Non-Compliance."

Providers can seek assistance with non-compliant members from TCHP by completing the "Physician Request for Member Education" form which is found in this section of the Provider Manual. Prior to requesting assistance from TCHP for non-compliant members, the provider must counsel the member regarding office policies for missed appointments. Counseling must be documented appropriately and may include notes in the medical record, documentation of appointment reminders, etc.

Following unsuccessful attempts to improve the situation, providers may proceed with requesting assistance from TCHP for non-compliant members. The provider must complete a separate "Physician Request for Member Education" form for each member. This form

(found in the Provider Manual), along with appropriate documentation, should be submitted to the TCHP Network Development Department. Network Development will coordinate member education with the Member Services Department within fourteen (14) days.

TCHP supports providers who require patients to have an appointment prior to being seen by the physician. Repeated failure to do so also is considered a form of "Patient Non-Compliance." TCHP will assist providers in educating members about this issue as described above.

In addition, TCHP supports providers who implement a "Missed Appointment" fee for Texas Children's Individual Medical Coverage (IMC) product members. Missed appointment fees are not a covered benefit. Therefore, it is imperative that providers appropriately notify IMC product members in advance of such fees. It is the provider's responsibility to collect missed appointment fees from these members.

Texas Children's Health Plan vision statement

Texas Children's Health Plan is committed to a community of healthy children by promoting the highest quality pediatric care, education, and research through efficient administration and care coordination.