NOVEMBER 2015

TEXAS CHILDREN'S HEALTH PLAN

ANNUAL NEWSLETTER

A publication of Texas Children's Health Plan for its providers.

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Texas Children's Health Plan
Member Services Department
P.O. Box 301011, NB 8360
Houston, TX 77230-1011

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Clinical Practice Guidelines

Texas Children's Health Plan, with the guidance of its Clinical & Administrative Advisory Committees, develops or adopts evidence based preventive care, acute care, chronic care and behavioral health standards and practice guidelines. Clinical practice guidelines are developed to assist practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health services.

Texas Children's Health Plan has Clinical Practice Guidelines in place including, but not limited to the following:

Allergy Guidelines:
- Allergy Diagnostic Testing
- Allergen Immunotherapy

Asthma Guidelines:
- Pediatric Asthma Care Guidelines
- Adult Asthma Care Guidelines

Behavioral Health Guidelines:
- American Academy of Child and Adolescent Psychiatry
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder.
- Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders
- American Society of Addiction Medicine Guideline
- Practice guideline for the treatment of patients with major depressive disorder
- DFPS/HHSC - Psychotropic Medication Utilization Parameters for Foster Children
- Institute for Clinical Systems Improvement, Health Care Guideline: Major Depression in Adults in Primary Care

State Behavioral Health Guidelines:
- Child Texas Recommended Assessment Guidelines (TRAG)
- Adult Texas Recommended Assessment Guidelines (TRAG)

Diabetes Guidelines:
- Diabetes Standards of Care
- Diabetes Care for Transition

Neuropsychology Guidelines:
- Neuropsychological Testing Guidelines

Otitis Guidelines:
- AAP Otitis Media with Effusion

Obesity Guidelines:
- NHLBI Obesity Guidelines for Adults

Pediatric Echocardiogram Guidelines:
- Pediatric Echocardiogram Guidelines
- Training Guidelines for Pediatric Echocardiogram

Perinatal Guidelines:
- Perinatal Guidelines

Pharyngitis:
- Pharyngitis Practice Guidelines

Preventative Care Guidelines:
- Texas Health Steps Periodicity Schedule
- Recommended Immunization Schedule Age 0-18
- Catch-up Immunization Schedule Age 0-18
- AAP Bright Futures Periodicity Schedule
- Adult Immunization Schedule Narrative
- Adult Immunization Schedule
- Adult Preventative Services

Tonsillectomy:
- Tonsillectomy in Children

Clinical practice guidelines are reviewed every 2 years and updated as needed. Texas Children's Health Plan disseminates the guidelines to the provider network and upon request, to members. These guidelines are available on the Texas Children's Health Plan website, Provider TouchPoint, or by FAX upon request by calling the Provider Information Line at 832-828-1008 or toll -free at 1-800-731-8527.

2015 Quality Assessment & Performance Improvement Program

Texas Children's Health Plan, has a Quality Assessment and Performance Improvement (QAPI) Program in place that seeks to provide safe, high quality health care and service to its members regardless of their source of eligibility. The QAPI program strives to include the full range of care and services offered through the health plan in its annual goals and objectives for improvement. This includes monitoring for quality, safety, coordination & continuity of care, and the availability and accessibility of medical & behavioral health services.

The QAPI program operates through a committee structure comprised of health plan staff, physicians, and behavioral healthcare practitioners participating in/advising the QI Committee or subcommittees that report to the QI Committee. The TCHP Board of Directors approved the authority, responsibilities and specific duties as described in the 2015 QAPI Program Description.

Annually the Texas Health & Human Services Commission (HHSC) and the National Committee for Quality Assurance (NCQA) require TCHP to report the results of designated performance measures including, the Healthcare Effectiveness Data & Information Set (HEDIS).

In 2015, TCHP met national benchmark rates at or above the 75th percentile for Well Child Care for 3 to 6 year olds for CHIP & STAR, Adolescent Well Care for STAR & CHIP, and Appropriate Use of Medications for People with Asthma. In the Behavioral Health area the TCHP rate for Follow-up Care for Children Prescribed ADHD Medication ranked in the 75th percentile.

Areas for continued improvement include: Prenatal and Postpartum Care (STAR); Childhood Immunization Status (STAR & CHIP); Diabetes Care (STAR); Appropriate Treatment of Upper Respiratory Infections and Appropriate Testing for Children with Pharyngitis (STAR & CHIP).

Texas Children's Health Plan teams including Quality Management, Medical Management, Provider Services and Member Services have implemented interventions to address needed improvements.

Information on the TCHP Quality Improvement program, annual goals, and progress towards goals is available upon request. You may request information by calling the Provider Information Line at 832-828-1008 or toll-free at 1-800-731-8527.

TCHP recognizes the efforts the practitioners and their office staff have contributed towards the high quality care and services provided our members. The following practitioners performed in the top 10 percent nationally and have received Quality Awards for their performance:

NGUYEN, HAI K
TREVINO-BEENE, ELIZA
GONZALEZ-MCDONNELL, HILDA I
KELLY, MARISE
NIKOLAIDIS, ANDREAS C
PARRA, CESAR A
PORRAS, CIRO J
TAHIR, SAIFUDDIN
BATRA, DIPESH
BEJARANO, ALDO F
BONTHALA, SAVITHRI
BRAWNER, MARLO
EGBE, JOYCE E
FOTOUH, ASMAA T
GANDHI, NITA S
GENDI, WAGIH A
GOIN, JOSEPH E
GOLDBERG, JACOBO
GONZALEZ, JAVIER A
GRILLO-PARIS, RICARDO
JEAN-LOUIS, FRANTZ
KHAN, LAEEQ A
KHAN, RUBINA F
NANDWANI, SHAMS S
ORDONEZ, ADOLFO J
PAHLAVAN, SILEN
PAHLAVAN, SOGOL
RAFIQ, SHAHID
RAMCHANDRA, MAHALAKSHMI
SALMERON-SERRANO, MARIE A
SANCHEZ-BURGOS, TEODORO Y
SHAH, SHAHZAD I
YEH, BELINDA M
BORNSTEIN, MICHAEL E
CHALLA, LYLA S
DEKA, KAMAL
DESAI, THRITY B
GARCIA, GILBERT M
HARDIN, CHERYL L
HOPE CLINIC - ASIAN AMERICAN HEALTH COALITION
JIA, JOHN Z
MENDOZA-RAMIREZ, JORGE S
MOORE, HEATHER C
ORTEGA, CESAR A
PALANPURWALA, KHOZEMA A
QUEJA, ELEANOR P
SANDLES, EVERETT L
SANTIAGO, MARY A
SULTANA, NIGHAT
TAGHADOSI, MARYAM
THE CENTER - GREENSPOINT
THE CENTER - SOUTHWEST
UDDIN, RAHMAN S
YUDOVICH, MARTIN
ABBAS, RASHIDA
AZIM, MOHAMMAD F
BARLAS, ZEBA
CHANG, JUNE-CHIEH
CLINE, MARRIETTA D
EVANS, DESIREE L
FARIZANI, FOROUGH
FERNANDEZ, ISAIRIS P
GUTIERREZ, CARLOS A
HANISSIAN, TALYNN A
HILL, REBECCA B
ISART, FERNANDO A
MENA, RAQUEL M
MOHI, SHAGUFTA Z
MONTGOMERY, HAL E
NAGHAVI, NANCY
NGUYEN, TUAN H
RAJPUT, MUHAMMAD B
RUBIN, MORTON L
SIDDIQUI, M HAROON
TORRES, LORA L
WONG-DOMENECH, MARIA T
WOOD, YING-YING P

Pharmacy

The Texas Children's Health Plan Pharmacy Department provides pharmacy benefit services to our STAR and CHIP members.

Our purpose is to provide accessible pharmacy care to ensure that services are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of pharmacy care.

The Texas Children's Health Plan Pharmacy Department works to partner with physicians to provide cost-effective care geared towards the goal of improving and maintaining the health of our members. The Texas Children's Health Plan Pharmacy Department considers itself a resource to the prescriber by providing useful notifications through periodical Drug Utilization Reviews (DURs), including pharmacy utilization patterns.

Texas Children's Health Plan provides its outpatient pharmacy drug benefit utilizing the Texas Medicaid Formulary, which currently encompasses more than 32,000 line items of drugs including single-source and multisource (generic) products.

The Texas Medicaid Formulary lookup can be accessed at the following web address:

http://www.txvendordrug.com/formulary/index.shtml

Preferred drugs are medications recommended as first-line pharmacotherapy agents by the Texas Pharmaceutical & Therapeutics (P&T) Committee for their efficaciousness, clinical significance, cost effectiveness, and safety for clients. The Texas Preferred Drug List (PDL) is published every January and July by the Texas Medicaid / CHIP Vendor Drug Program. The Texas Formulary Preferred Drug List (PDL) products are available to providers when prescribing for patients covered by the pharmacy benefit plan offered by Texas Children's Health Plan without prior authorization. The drugs listed in this PDL are intended to provide sufficient options to treat patients who require therapy with a drug from a pharmacologic or therapeutic class.

The Preferred Drug List (PDL) is available for download at the following web address:

http://www.txvendordrug.com/pdl

Additionally, both the Texas Drug Code Medicaid Formulary and the corresponding Preferred Drug List (PDL) are available on the Epocrates drug information system. The service is free and provides instant access to information through the internet or smart phone about the products on the Texas

Medicaid Formulary. Information about accessing the Texas Medicaid Formulary and the Preferred Drug List (PDL) via Epocrates can be viewed at the following web address:

http://www.txvendordrug.com/formulary/epocrates.shtml

Texas Children's Health Plan internally maintains a Pharmacy, Therapeutics and Technology (PT&T) Committee which continuously reviews the Texas Medicaid Formulary and the Preferred Drug List (PDL), assesses the current clinical edit criteria and the status of drug products as preferred or non-preferred, and provides input to the Texas Vendor Drug Program Pharmaceutical & Therapeutics Committee (PT&T). The Texas Children's Health Plan PT&T committee, comprised of practicing physicians and pharmacists in Texas Children's Health Plan's service areas, meets quarterly to review the Texas Medicaid Formulary.

The Texas Children's Health Plan highly encourages our network practicing prescribing practitioners and pharmacists to provide expert commentary regarding the Texas Medicaid Formulary. Please submit comments or suggestions regarding the formulary to TCHPpharmacy@texaschildrens.org.

Texas Children's Health Plan has contracted with Navitus as our Pharmacy Benefit Manager (PBM), who is responsible for:

- Texas Children's Health Plan's network of pharmacies.
- Pharmacy claim concerns.
- Administration of the Texas Medicaid and CHIP drug formulary.
- Prior authorization for non-preferred medications on the Texas Medicaid Formulary.
- Prior authorization for HHSC specialty drugs cross-referenced to the Texas Medicaid Formulary.
- Program Administration of Clinical Edits.
- Administration of Quantity Limits.
- Provider request for peer-to-peer review of prior authorization denials.
- Coordination of Benefits at retail point of sale.
- Receipt and payment of pharmacy claims. Complaints from pharmacies and pharmacy reimbursement concerns.

Navitus has contracted with more than 95% of the current Vendor Drug Program pharmacy Providers in Texas. The Navitus pharmacy network includes the national chain pharmacies (e.g. Walgreen's, CVS, HEB, Wal-Mart, Target, and Kroger's), as well as a large number of independent pharmacies. Navitus' pharmacy network can be accessed online at

https://www.navitus.com/texas-medicaid-star-chip/pharmacy-directory.aspx

Providers may call Navitus at 1-866-333-2757 to inquire about prior authorizations, clinical edits, quantity limits or to request a peer–to-peer review. Texas Medicaid Formulary drugs requiring prior authorizations, the prior authorization forms, and all Texas Children's Health Plan currently implemented clinical edits can be found at the following web address:

https://www.navitus.com/texas-medicaid-star-chip/prior-authorization-forms.aspx

The Texas Medicaid Formulary, including the Preferred Drug List and any clinical edits that specify the prior authorization process for non-preferred agents are defined by the Texas Vendor Drug Program.

Quantity Limits

A quantity limit may reduce the number (or amount) of drugs covered within a certain time period. Quantity limits are designed to limit the use of selected drugs for quality and safety reasons. The quantity limit for each drug is supported by FDA-recommended use of the product and per approved dosing instruction in the package insert. This utilization management program encourages appropriate drug use. If a quantity limit is programmed for a medication and the prescription is outside of this predetermined quantity limit the local pharmacist will review the original request for safety. If the drug is deemed safe at this higher dose/quantity a supply of up to 15 days will be dispensed. The Provider should contact Navitus to request a prior authorization approval for this dose to fulfill any balance request of the larger quantity per day supply.

Step Therapy

Step therapy is an approach to prescription coverage intended to control the costs and risks posed by prescription drugs. A step therapy edit starts with the most cost-effective and safest drug therapy and progresses to other more costly or less safe therapies only if necessary. Currently, the Texas Vendor Drug Program PDL is enforced for Texas Children's Health Plan STAR/CHIP Medicaid

Members. Step Therapy edits are not part of the Texas Vendor Drug Program at this time.

Generic Substitution

The Texas Medicaid Formulary as defined by the Texas Vendor Drug Program has a list of preferred medications on the Preferred Drug List (PDL). A drug that is covered under this PDL may be either brand or generic. Both the brand and its available generic generally are not both covered. Thus, generic substitution does not routinely occur since only one product will be the covered entity.

The prescriber is encouraged to reference the Texas Medicaid Formulary and the Preferred Drug List (PDL) when prescribing medication for the most up-to-date, covered medication.

Therapeutic Interchange

Therapeutic interchange involves the dispensing of medications which are chemically different, but therapeutically similar in nature.

Therapeutic interchange generally occurs for cost control and under the approval of a prescriber. We do not refuse coverage of any covered product under the Texas Medicaid Formulary and its associated Preferred Drug List in lieu of a similar covered product for cost control reasons. We may, however, contact the Provider to provide education on the Texas Medicaid Formulary and the

Preferred Drug List (PDL) which defines all of the covered alternatives available for Members. Any changes to medication at any time should only be made under the Provider's careful consideration.

Formulary Updates and Communications

Texas Children's Health Plan reviews and modifies necessary rules, limitations, and guidelines periodically throughout the year.

This policy is to ensure effective communication to the practitioner and provider community is updated frequently. At a minimum, practitioners and providers will be updated using a combination of both passive and active means such as newsletters, internet, direct mail, provider manuals, fax alerts, and face-to-face interaction.

CHIP Member Rights and Responsibilities

Member Rights

1. You have the right to information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for 3 months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your 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 your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your Health Plan. You may have to pay a copayment depending on your income.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated with respect, dignity, privacy, confidentiality, and nondiscrimination by your health plan, doctors, hospital, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals, and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to appeal and have another group, outside the health plan, tell you if they think your doctor or the health plan is right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's 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.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have the right to make recommendations regarding the organization's member rights and responsibility policy. If you think that you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must follow plans and instructions for care and they have agreed to with their practitioners.
4. You must work together with your health plan's doctors and other providers to follow treatments for your child that you have all agreed upon.
5. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
6. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
7. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
8. If your child has CHIP, you are responsible for paying your doctor and other provider's copayments that you owe them.
9. You must report misuse of CHIP services by health care providers, other members or health plans.
10. You must talk to your provider about all of your medications that are prescribed.
11. You must learn and understand your child's health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
12. You must supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019.

You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Member's Right to Designate an OB/GYN

Texas Children's Health Plan allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider.

An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Medicaid Member Rights and Responsibilities

Member Rights

1. You have the right to be treated with 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.
   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 or your child regardless of cost or benefit coverage.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use 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. A right to receive information about the organization, its services, its practitioners and providers, and 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 copayment or any other amounts for covered services.
10. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

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 maintain your health. 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.
5. You must follow plans and instructions for care that you have agreed to with your provider.

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

Authorization for Health Services

Effective September 1, 2015

The primary care provider acts as the coordinator for health care provided to Texas Children's Health Plan STAR members, both within and outside of the primary care provider's office. The primary care provider has the primary responsibility for arranging and coordinating appropriate referrals to other providers/specialists, as well as managing and coordinating the administrative functions related to the delivery of health services in conjunction with Texas Children's Health Plan and case managers as indicated.

The primary care provider or designee may make medically necessary referrals to in-network specialists, ECI, family planning, CPW, Texas Health Steps, or mental health and emergency services without authorization from Texas Children's Health Plan.

Current services requiring authorization are listed below, but please check with Texas Children's Health Plan Utilization Management at 832-828-1004, option 5 or Provider TouchPoint at www.tchp.us/providers for updates to this list.

Authorizations for in network specialists are not required. The following services require authorizations.

Medical Authorizations

- All genetic testing
- All out-of-network services
- Ambulance services (non-emergent transport)
- Augmentative Communication Devices
- Baclofen injections/pump
- Bariatric Surgery
- Botox Injections
- Chemotherapy non-FDA approved
- Circumcision greater than 1 year of age
- Cochlear Implant
- Contact lenses due to disease process
- Cosmetic Surgery
- Cranial Molding Orthosis (Helmets)
- Dental Medically necessary (except for cleft palate)
- Gait trainer
- Home Health Care
- Hospital grade Blood Pressure Monitors in home use
- Hospital Beds and accessories
- Hospital Inpatient care
- Nutritional Supplements
- Oral Surgery
- Organ Acquisition
- PET Scans
- Prescribed Pediatric Extended Care Centers
- Private Duty Nursing in home
- Progesterone Therapy
- Prosthetics
- Skilled Nursing facility
- SPECT Scans
- Therapy – Physical, Occupational,Speech
- (including initial Eval)
- TMJ diagnosis and treatment
- Transplant Evaluation
- Vision Care, medically necessary
- Wheelchairs and accessories

Behavior Health Authorizations

- All out-of-network services
- Inpatient Care
- Intensive Outpatient Treatment
- Neuropsychological Testing
- Outpatient Behavior Health visits greater than 30 (per Calendar year)
- Partial Hospitalization
- Psychological Testing (excluding initial evaluations)
- Residential Treatment Facility
- Targeted Case Management
- Substance Use Disorder Treatment (excluding evaluations)

Authorizations for these services must be submitted to Texas Children's Health Plan by faxing the authorization form to 832-825-8760 or calling 832-828-1004. Behavioral Health authorizations go to Behavioral Health toll-free FAX 1-844-291-7505. The primary care provider will remain responsible for ensuring continuity of the member's care by maintaining medical record documentation of treatment rendered.

Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

To contact Utilization, Case and Disease Management Services, Providers may reach TCHP UM Department, Monday through Friday from 8 a.m. to 6 p. m. at 832-828-1004 or by fax at 832-825-8760.

Authorization of Clinician-Directed Care Coordination for Medically Complex Members

1. Services require an authorization by the member's Texas Children's Health Plan case manager.
2. Authorization must be obtained within 7 days of the initial date of service.
3. Each authorization is for a period of 6 months and must be preceded by a face-to-face visit within the preceding 6 months.
4. Authorizations for care plan oversight will only be made to the members' medical home provider. The authorization will be for 2 services every 6 months and require a care plan and emergency medical plan be in place for the member (both evidenced in documentation as multidisciplinary care documents), which include a problem list, interventions, short and long term goals as well as responsible parties.
5. Medical team conference authorizations allow one service every 6 months to be authorized to the primary care physician or a specialist for a member who is currently enrolled in a Texas Children's Health Plan case management program.
6. Non-face-to-face prolonged services are billable for member's enrolled in a Texas Children's Health Plan case management program when a significant condition change occurs (complex discharge planning, trauma complications to current condition, or a new diagnosis). Each of the preceding is to require interdisciplinary care coordination by the billing provider.
7. Medical records are subject to retrospective review to establish documentation and times of services.

Definitions of medically complex and multidisciplinary care are defined by Texas Children's Health

Plan as documented in the Texas Medicaid Bulletin, No. 209 p. 163.

Calls for authorization may be placed at 832-828-1004. Texas Children's Health Plan will respond within 3 business days of the request for authorization. Failure to comply with this process may result in nonpayment of claims.

If you need further assistance or clarification, please contact your provider relations manager or call the Provider Relations telephone line at 832-828-1008.

Complex Case and Disease Management Program

Services offered to Texas Children's Health Plan providers include case management for chronic, complex conditions, and pregnant women. Specific disease management programs designed to assist primary care providers with effective management of asthma, diabetes, attention deficit hyperactivity disorder, and obesity are available.

Health Plan care managers enroll members into both disease management and/or case management programs. A referral initiated by the provider is requested to start the services. An assessment and care plan are completed on the patient and referrals and services are provided to the parent/member. The primary care provider is given a care plan for members enrolled in case/disease management programs. Providers should include the care plans in the patient's medical record.

Follow-up calls with phone coaching are done monthly to monitor the patient/parent progress with the plan of care. The care manager collaborates closely with the member's primary care provider to share relevant health information whose goal is to positively impact the member's adherence to the medical treatment plan.

Panel patient information available to providers includes disease registries for members with asthma, diabetes, ADHD, and obesity. Individual patient information available includes the number of emergency room/inpatient visits per patient, number of provider and specialist visits per patient, and medication refill information. The care managers are available to do group teaching classes for asthma and obesity patients in provider offices.

Providers may request these services by calling the Care Management Department at 832-828-1430. Referral forms are available for download at www.texaschildrenshealthplan.org/providers.

Once completed, the forms may be faxed to:

Care Management Department-832-825-8745 for members with chronic or complex conditions

Disease Management Department-832-825-8705 for pregnant members

Behavioral Health Department-832-825-8767 for members with a behavioral health condition

Quality Care Coordination

Care coordination addresses potential gaps in meeting our members' interrelated medical, social, behavioral, educational, and financial needs to achieve the best health and wellness outcomes.

Its goals are to ensure that individualized needs and preferences are recognized and that high quality and efficient care is delivered for best outcomes. Case managers, social service professionals, and trained health-care workers all play a key role in managing the care of the individuals by providing guidance through the health-care system either telephonically or in a face-to-face visit with the member.

Individuals who have multiple ongoing needs—that can't be met by a single practitioner or by a single clinical organization—need care coordination the most.

Care coordination has 3 primary focus areas:

1. Support of self-management through education, advocacy (specialist access, school nurse), shared decision making, and flexibility with individuals and families by connecting with prevention and wellness services.
2. Coordination of assessment data and health information.
3. Promoting connections to care delivery and transition support from pediatrics into adult care.

Comprehensive care coordination develops a plan of care including clinical (medical and behavioral) and social service needs and wellness goals.

Comprehensive care coordination:

1. Establishes a connection to supports and services at home, school, and community; and
2. Provides access to family support services to enhance the success and strength of the family in navigation and advocacy.

The process of developing an informed and activated member/family and prepared, proactive practice team rests with care coordination, and its techniques are based on Wagner's Chronic Care Model (informed activated patient with a prepared proactive practice team).

You can find a referral form for case management on the Texas Children's Health Plan website. Fax it to 832-825-8745 or call the care coordination number at 832-828-1430 for more information.

Availability of Criteria to Practitioners

It is the policy of Texas Children's Health Plan to use written criteria based on clinical evidence for appropriate case application in adjunct to a review of individual circumstances and local health system structure when determining medical appropriateness of health care services. Criteria used in making a determination will be made available upon request.

Texas Children's Health Plan has written decision-making criteria that are objective and based on Medical evidence.

This includes:

- InterQual Level of Care Criteria, McKesson, 2014: Acute Care Pediatric
- InterQual Level of Care Criteria, McKesson, 2014: Acute Care Adult
- InterQual Level of Care Criteria, McKesson, 2014: Outpatient Rehabilitation & Chiropractic, Adult & Pediatric
- InterQual Care Planning Criteria, McKesson, 2014: Molecular Diagnostics
- InterQual Care Planning Criteria, McKesson, 2014: Durable Medical Equipment
- InterQual Behavioral Health Criteria, McKesson, 2014: Adult Psychiatry
- InterQual Behavioral Health Criteria, McKesson, 2014: Adolescent Psychiatry
- InterQual Behavioral Health Criteria, McKesson, 2014: Child Psychiatry
- InterQual Behavioral Health Criteria, McKesson, 2014: Substance Use Disorders & Dual Diagnosis
- InterQual Behavioral Health Criteria, McKesson, 2014: Residential & Community-Based Treatment
- Texas Children's Health Plan Behavioral Health Neurological/Psychological Testing Child/Adolescent Guidelines, 2014
- Texas Children's Health Plan Therapy Criteria, October 1, 2015
- DSM-V, American Psychiatric Association, Fifth Edition, 2013
- Texas Medicaid Provider Procedures Manual, Current Version
- Department of State Health Services (DSHS) Texas Resilience and Recovery (TRR) Utilization Management Guidelines 2014 (Formerly RDM) September 1st, 2014
- Texas Resilience and Recovery Utilization Management Guidelines - Adult Services April 10, 2014
- Texas Resilience and Recovery Utilization Management Guidelines- Child and Adolescent Services August 8, 2013
- Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, Psychotropic Medication Utilization Parameters for Children and Youth In Foster Care, September 2013

Affirmative Statement

Texas Children's Health Plan decisions are made on appropriateness of care and service as well as coverage availability. Texas Children's Health Plan does not reward practitioners or other staff for issuing denials of coverage. Financial incentives are not in place relating to Utilization Management decision results. Texas Children's Health Plan does not hire, promote, or terminate based on the likelihood that a practitioner will support or tend to support the denial of benefits.

Understanding Waste, Abuse and Fraud

The Office of Inspector General (OIG) is continuously monitoring the populations served by the HHS enterprise for instances of fraud, abuse and waste. In order to provide a better understanding of the OIG's efforts in detecting, deterring and correcting incidents of fraud, abuse and waste, please refer to their website: **oig.hhsc.state.tx.us/oigportal/**. Incidences of fraud, abuse and waste can also be reported through the OIG's website.

If there is a particular topic you would like to have addressed, please contact the OIG at OIG.GeneralInquiries@hhsc.state.tx.us.

Reporting Changes to the Health Plan

Providers must notify Texas Children's Health Plan at least 30 days calendar days prior to changes to the provider data listed below. Changes not received in writing are not valid. If Texas Children's Health Plan is not informed within the timeframe, Texas Children's Health Plan and its designated claims administrator are not responsible for the potential claims processing and payment errors.

Network providers must also notify the Health and Human Services Commission administrative services contractor of any change that involves a provider's address, telephone number, group affiliation, etc.

Please contact Texas Children's Health Plan Provider Relations in writing to report any of the following changes:

- Name
- Address
- Office Hours
- Coverage procedures
- Corporate number
- Telephone number
- Specialty change
- Tax ID number
- Medicaid Provider number
- Permit to practice
- Address Professional liability insurance coverage
- Professional liability insurance coverage
- Limits placed on practice
- Status of hospital admission privileges
- Contract status change
- Opening/closure of panel
- Patient age limitations
- DEA number
- DPS number
- Other information that may affect current contracting relationship

*Hours of operation that practitioners offer to Medicaid members should be no less than those offered to commercial members.

Please contact Provider Relations with reported changes at 832-828-1008 or toll-free at 1-800-731-8527.

Preventive Health Services

Providing preventive health services in accordance with the STAR/CHIP programs and related medical policies. The preventive health services will include, but are not limited to, the following:

- Annual well checkups for all adult members age 21 and older.
- Education of members about their right to self-refer to any network OB/GYN provider for OB/GYN health-related care.
- Immunizations, TB screenings, and other measures for the prevention and detection of disease, including instructions in personal health care practices and information on the appropriate use of medical resources.
- Adherence to Texas Health Steps periodicity schedule for STAR and American Academy of Pediatrics (AAP) Guidelines for CHIP.
- Complying with all prior authorization and certification requirements and admitting patients in need of hospitalization only to network facilities or contracted hospitals unless:
  - Prior authorization for admission to an out-of-network facility has been obtained from Texas Children's Health Plan.
  - The condition is emergent and the use of a network hospital is not practical for medical reasons.

Preventive Health Guidelines - Texas Health Steps Program

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health service for individual's birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps (THSteps).

EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing preventive services. In addition, section 1905(r)(5) of the Social Security Act requires that any medically necessary healthcare service listed in the Act be provided to Texas Health Steps clients even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. These additional services are available through the Comprehensive Care Program (CCP).

The Texas Medical Assistance (Medicaid) Program was implemented September 1, 1967, under the provisions of Title XIX of the Federal Social Security Act and Chapter 23 of the Texas Human Resources Code. The cost of Medicaid is shared by the State of Texas and the federal government. The Texas Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of the program is accomplished through contracts and agreements with medical providers, claims administrators (claims reimbursement processor), enrollment brokers, various managed care organizations, and state agencies including the Department of Assistive and Rehabilitative Services (DARS), and Department of State Health Services (DSHS). Medicaid providers, including those providing Texas Health Steps services, are reimbursed for their services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

The goals of the Texas Health Steps Program are as follows:

- Emphasize the prevention, early detection and treatment of medical and dental problems in Medicaid clients from birth through 20 years of age.
- Associate clients with primary care providers able to meet their health care needs.
- Offer preventive medical and dental care and treatment before health problems become chronic or irreversible.
- Offer comprehensive services that are available statewide through private and public providers.
- Encourage client use of preventive services.
- Expand client awareness of services offered.

Under the Texas Health Steps Program, newly enrolled members must have a medical checkup (unless the member refuses) within 90 days of new enrollment and based upon the American Academy of Pediatrics and the Texas Health Steps Periodicity Schedule. Newborns must receive an initial checkup before discharge from the hospital and another checkup between discharge and age five days. Migrant families with eligible children may access accelerated services.

All members will have access to Texas Health Steps services that are conveniently located so that members do not face unreasonable scheduling delays, appointment waiting time, and travel time. Since public schools support the Texas Health Steps Program, children may be excused from school for Texas Health Steps medical and dental checkups.

Texas Children's Health Plan members are not limited to visiting in-network providers for Texas Health Steps services. They may visit any Texas Health Steps provider in order to receive Texas Health Steps services.

The Texas Department of State Health Services (DSHS) Laboratory, located in Austin, performs free laboratory testing on blood specimens collected by all Texas Health Steps medical checkup providers. The DSHS laboratory also furnishes providers with free laboratory collection supplies and postage-paid mailing containers. The DSHS Women's Health Laboratory in San Antonio provides collection supplies and processing for STD tests. Tests which are required to be sent to the DSHS labs include gonorrhea/Chlamydia, hemoglobin, and the initial lead test, with the exception of lead testing performed with a point of care device in the provider's office. For other tests, the client or specimen may be sent to the laboratory of the provider's choice. For more information concerning your responsibilities as a participating provider with the HHSC STAR program please refer to your Texas Medicaid Provider Procedures Manual located on the TMHP website at www.tmhp.com. Information concerning the Texas Medicaid Provider Procedures Manual-Texas Health Steps can be accessed at www.tmhp.com. We also encourage our providers to access the Texas Medicaid Bimonthly and Special Bulletins by going to www.tmhp.com.

Care Management – Utilization, Case and Disease Management

- Prior authorization request.
- Concurrent review.
- Notification of admissions.

Phone: 832-828-1004 or 1-877-213-5508
Fax: 832-825-8760
Hours of operation: 8 a.m. to 6 p.m., Monday through Friday.

How to Contact Utilization Management

Texas Children's Health Plan Utilization Management (UM) staff is available from 8 a.m. to 6 p.m. Monday through Friday for inbound calls regarding UM issues. Messages left for UM staff after hours by phone or fax are returned the next business day. Inbound messages may be left at any time. Texas Children's Health Plan UM staff are available to answer questions about the UM process and/or to receive information about a UM transaction during normal office hours or they will call back the next working day.

Texas Children's Health Plan offers TDD.TTY services for deaf, hard of hearing or speech impaired members. Language line assistance is available to UM staff, if needed, in discussion with members or practitioners for any UM issue.

STAR Plan Members

Any questions the member may have regarding decisions made by UM should be directed to:

Texas Children's Health Plan
Attn: Member Services Department
P. O. Box 301011, NB 8390
Houston, TX 77230-1011
1-866-959-2555 or
1-832-828-1001 option 5
FAX 832-825-8760

CHIP Plan Members

Any questions the member may have regarding decisions made by UM should be directed to:

Texas Children's Health Plan
Attn: Member Services Department
P.O. Box 301011, NB 8390
Houston, Texas 77230-1011
1-866-959-6555 or
1-832-828-1002 option 5
FAX 832-825-8760

Authorization and Appeals Process

Requests for procedures and services are submitted by the health care provider for services requiring prior authorization. If a request for services is denied by Texas Children's Health Plan, the member will receive a letter indicating the reason why services are being denied. The member has the right to appeal a denial of services.

Members may represent themselves or be represented by the health care provider, a friend, a relative, legal counsel, or another spokesperson. Texas Children's Health Plan will make a decision within 30 days of receiving the request for appeal.

For STAR plan members, all appeals regarding services that have not been rendered or have already been delivered should be directed to:

Texas Children's Health Plan
Attn: Appeals Department
P.O. Box 301011, NB 8390
Houston, Texas 77230-1011
1-866-959-2555 or
1-832-828-1001

For CHIP plan members, all appeals regarding services that have not been rendered or have already been delivered should be directed to:

Texas Children's Health Plan
Attn: Appeals Department
P.O. Box 301011, NB 8390
Houston, Texas 77230-1011
1-866-959-6555 or
1-832-828-1002

An expedited appeal may be placed when Texas Children's Health Plan determines or the provider indicates to Texas Children's Health Plan that routine appeal time frames could jeopardize the member's child's life, health or ability to recover a function. Texas Children's Health Plan will make a decision within 3 days of receiving the request.

Learn More Information on our Provider Portal

You can go to our website and log-in to Provider TouCHPoint to learn more on topics like:

- Quality program goals, processes, and outcomes
- Pharmaceutical management procedures
- Formulary
- Limits/quotas
- Supporting an exception process
- Member rights and responsibilities
- Generic substitution, therapeutic interchange, and steptherapy protocols
- Clinical practice guidelines and preventive health guidelines
- Referrals to case management
- Disease Management Programs
- How practitioners can access authorization criteria
- Availability of staff to discuss authorization process
- Availability of TDD/TTY services
- Availability of language assistance for members
- Prohibiting financial incentives for utilization management decision makers

Texas Children's Health Plan Phone Numbers

Member Services

- Information about CHIP or STAR.
- Eligibility/benefits questions.

STAR members:
832-828-1001 or 866-959-2555
CHIP members:
832-828-1002 or 866-959-6555
Telephone TouCHPoint: 832-828-1007
Fax: 832-825-8777

Care Management—Utilization, Case and Disease Management

- Prior authorization request.
- Concurrent review.
- Notification of admissions.

Phone: 832-828-1004
Fax: 832-825-8760
Hours of operation: 8 a.m. to 6 p.m., Monday through Friday

Provider and Care Coordination

- Inquiries regarding Texas Children's Health Plan policies and procedures.
- Contract clarification.
- Fee schedule inquiries.
- Change of address/phone number notification.
- Requests for provider directories.
- Information on provider educational in-services.

Phone: 832-828-1008
Toll-free: 1-800-731-8527
Fax: 832-825-8750

Provider Hotline

- Claim status, questions and information.
- Questions about how a claim was processed.

Phone: 832-828-1004

STAR Dental Services

- DentaQuest 1-800-516-0165 (STAR)
- DentaQuest 1-800-508-6775 (CHIP)
- MCNA Dental 1-800-494-6262

Texas Children's Health Plan Nurse Help Line

Phone: 1-800-686-3831

Electronic Funds Transfer (EFT)

Emdeon: 1-866-506-2830

Pharmacy Hotline

Navitus: 1-877-908-6023

Behavioral Health Hotline and Referral Line (STAR)

1-800-731-8529

Behavioral Health Hotline and Referral Line (CHIP)

1-800-731-8528

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