



Texas Children's[®]
Health Plan

April 2017

Texas Children's Health Plan
Provider and Care Coordination



Provider Training

832-828-1008 • Toll free 800-731-8527 • TexasChildrensHealthPlan.org



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Introduction

What is the STAR Kids Program?

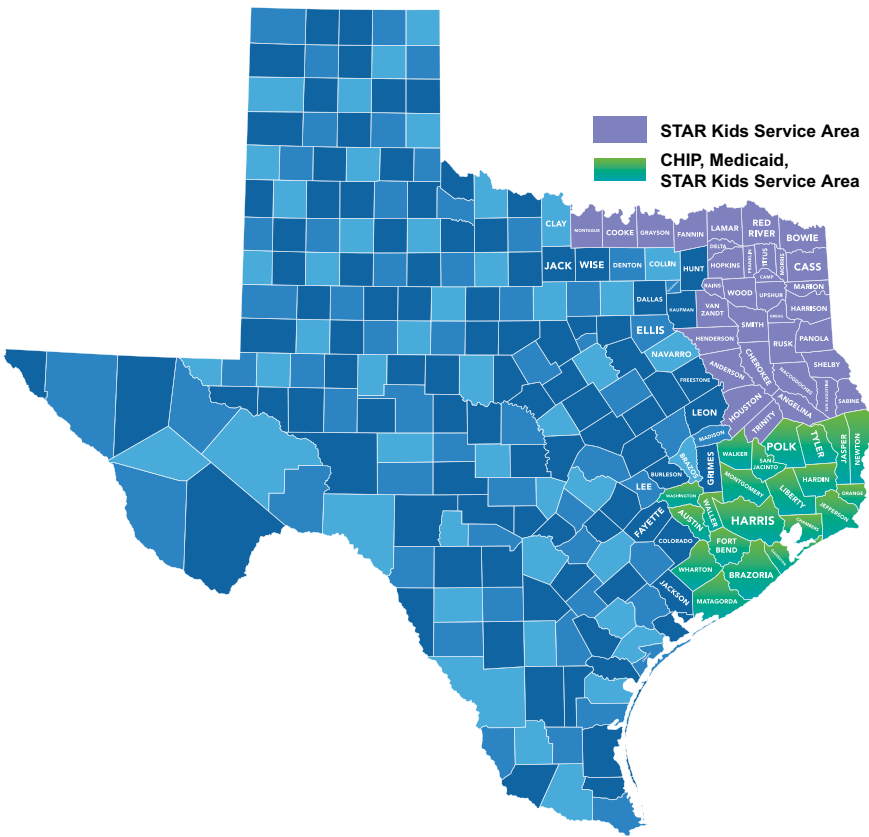
The STAR Kids program is a Medicaid managed care program designed to meet the unique needs of children and youth with disabilities. The program will provide acute care benefits and long-term services and support, such as, private duty nursing, personal care services, and some waiver services.

Through STAR Kids, families will receive help with coordinating care. Service coordinators will identify needs and connect members to services

A core component of the STAR Kids program is a standard screening and assessment process, called the STAR Kids Screening and Assessment Instrument.

Where does Texas Children’s Health Plan provide STAR Kids services?

Texas Children’s Health Plan serves children with medical complexities in the Jefferson and Harris service areas as well as more than 30 counties in the northeast Medicaid rural areas.



Harris

- Austin
- Brazoria
- Fort Bend
- Galveston
- Harris
- Matagorda
- Montgomery
- Waller
- Wharton

Jefferson

- Chambers
- Hardin
- Jasper
- Jefferson
- Liberty
- Newton
- Orange
- Polk
- San Jacinto
- Walker

Northeast

- Anderson
- Angelina
- Bowie
- Camp
- Cass
- Cherokee
- Cooke
- Delta
- Fannin
- Franklin
- Grayson
- Gregg
- Harrison
- Henderson
- Hopkins
- Houston
- Lamar
- Marion
- Montague
- Morris
- Nacogdoches
- Panola
- Rains
- Red River
- Rusk
- Sabina
- San Augustine
- Shelby
- Smith
- Titus
- Trinity
- Tyler
- Upshur
- Van Zandt
- Washington
- Wood

Texas Children's Health Plan STAR Kids

Texas Children's Health Plan has developed collaborative relationships with advocacy groups and providers of LTSS to better understand covered services that will now be provided to our members.

Texas Children's Health Plan's approach to building a robust network for community based services includes:

- Developing and maintaining a network that includes agencies that specialize in caring for children and adolescents with complex medical needs and intellectual challenges
- Developing incentives to encourage and reward providers for the provision of timely and quality care
- Continuing to monitor and evaluate our network to identify gaps or missing services, and recruiting new providers as our health plan membership grows

Who must participate in STAR Kids?

Medicaid populations, including children and young adults aged 20 and younger, must participate in STAR Kids when receiving the following services:

- Supplemental Security Income (SSI)
- SSI and Medicare
- Medically Dependent Children Program (MDCP) waiver services
- Youth Empowerment Services (YES) waiver services
(State plan services, service coordination, and Community First Choice waiver services, YES waiver services will continue to be provided through the YES waiver)
- IDD waiver services (e.g., CLASS, DBMD, HCBS, TxHmL, see table below)
(State plan services and service coordination only, LTSS services will continue to be provided through the IDD waivers)
- Residing in a community-based ICF-IID or in a nursing facility (NF)
(State plan services and service coordination only, LTSS services will continue to be provided through the appropriate institution)
- Medicaid Buy-in Program

Individuals excluded from participating in STAR Kids

- Anyone age 21 years or older
- Children and young adults age 20 and younger enrolled in STAR Health or receiving adoption assistance or adoption services
- Children and young adults age 20 and younger who reside in the Truman Smith Children's Care Center

STAR Kids Eligibility

Eligibility for STAR Kids is determined by the Texas Health and Human Services Commission. Once eligible, members select enrollment in a managed care organization in their area through the administrative services contractor

It is the responsibility of all treating providers to verify that the patient continues to be a Texas Children's Health Plan member throughout the treatment period. Verification of eligibility may be made by:

- Visiting Texas Children's Health Plan online at www.tchp.us/providers (Providers must fill out the Texas Children's Health Plan Secure Access Application to become an authorized user. For more information on Texas Children's Health Plan's secure access call Provider Relations at 832-828-1008.
- STAR Kids Providers can receive eligibility information by calling the STAR Kids Provider Eligibility Hotline Monday through Friday 8:00 AM to 5:00 PM (Central Time). Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently enrolled STAR Kids Member. The hotline number is 832-828-1004 or toll free at 1-877-213-5508.

Texas Children's Health Plan STAR Kids

STAR Kids Waivers

Waivers let states use Medicaid funds for long-term home and community-based services for people with disabilities or special health-care needs and the elderly in order to help them live in the community.

Before the creation of waiver programs, people had to live in hospitals, nursing homes, or institutions such as Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), so that Medicaid would pay for long-term services.

They are named "waivers" because certain Medicaid requirements are waived. Children and youth who receive services through other 1915(C) waiver programs will receive their basic health services (acute care) through STAR kids.

For more information on waivers, please visit <https://www.navigatelifetexas.org/en/insurance-financial-help/texas-medicaid-waiver-programs-for-children-with-disabilities>

- **Community Living Assistance and Support Services (CLASS) Waiver Program** The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.
- **Deaf Blind with Multiple Disabilities (DBMD) Waiver Program** The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.
- **Dual-Eligible** Medicaid recipients who are also eligible for Medicare.
- **Home and Community-based Services (HCS) Waiver Program** The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.
- **Long Term Services and Supports (LTSS)** LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.
- **Medical Dependent Children Program (MDCP) Waiver Program** The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.
- **Texas Home Living (TxHmL) Waiver Program** The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.
- **Youth Empowerment Services (YES) Waiver Program** The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

Texas Children's Health Plan STAR Kids

Waivers

Services	Class	MDCP	DBMD	HCS	TxHmL	YES
Adaptive aids and medical supplies	✓	✓	✓	✓	✓	✓
Assisted living			✓			
Audiology			✓		✓	
Behavioral support services	✓		✓		✓	
Case management	✓		✓			
Chore provider			✓			
Cognitive rehabilitative therapy	✓					
Community support services					✓	
Continued family services	✓					
Day habilitation				✓	✓	
Dental services	✓		✓		✓	
Dietary services			✓		✓	
Employment Assistance	✓	✓	✓	✓	✓	✓
Environmental accessibility			✓			
Family support services		✓				✓
Financial Management Services	✓	✓	✓	✓	✓	
Habilitation						
Intervener			✓			
Minor home modification	✓	✓	✓	✓	✓	✓
Non-medical transportation						✓
Nursing services	✓		✓		✓	
Occupational therapy	✓		✓			
Orientation and mobility			✓		✓	
Paraprofessional services						✓
Physical therapy	✓		✓		✓	
Pre-engagement services						✓
Prescription drugs (not covered by Medicare)			✓			
Prevocational habilitation	✓					
Residential habilitation			✓	✓		
Respite care	✓	✓	✓	✓	✓	✓
Specialized therapies						✓
Speech and hearing therapy			✓			
Speech and language pathology	✓				✓	
Support consultation	✓		✓			
Support family services	✓					
Supported Employment	✓	✓	✓	✓	✓	✓
Supportive family-based alternatives	✓					✓
Transition assistance services	✓	✓	✓			✓

Waiver Program

CLASS	Community Living Assistance and Support Services
MDCP	Medically Dependent Children Program
DBMD	Deaf Blind with Multiple Disabilities
HCS	Home and Community-based Services
TxHmL	Texas Home Living

Texas Children's Health Plan STAR Kids

STAR Kids Covered Services

The STAR Kids program benefits are governed by Texas Children's Health Plan's contract with the Health and Human Services Commission. The following is a non-exhaustive, high-level listing of Covered Services included under the STAR Kids Medicaid managed care program:

- Medical
- Vision
- Behavioral health
- Pharmacy
- Therapies – physical, occupational and speech
- DME/Medical Supplies
- LTSS
- MDCP services are covered for individuals who qualify

For a more comprehensive list of covered services, refer to the Texas Medicaid Provider Procedures Manual (TMPPM) STAR Kids manual.

Additional Covered Services

Early Childhood Intervention services

Early Childhood Intervention (ECI) services is a statewide program for children, birth to three, with disabilities and developmental delays. With ECI support, families can help their children reach their potential through developmental services.

Medical Transportation Program services

The Medical Transportation Program (MTP) provides transportation services to Medicaid eligible clients that have no other means of transportation. MTP may also pay for an attendant if a provider documents the need, the member is a minor, or there is a language barrier. MTP can reimburse gas money if the member has an automobile but no funds for gas.

Depending on the client's medical need and location, MTP can arrange for transportation by mass transit, van service, taxi, or airplane. In addition, for clients under 21 years of age, MTP can assist with meals and lodging for medical services when an overnight stay is medically necessary.

LTSS covered services include:

Long term service and supports are services like attendant care, nursing, and respite care that take place in the home or community.

These are home and community based services and supports used by individuals with functional or cognitive limitations and/or those with chronic illnesses who need assistance to live in an independent setting versus a facility or institution.

Commonly utilized services includes help with performing routine daily activities such as bathing, dressing, preparing meals and administering medications.

Day activity and health services, attendant care, and private duty nursing will be available to all members that qualify.

Community First Choice, is an attendant care benefit, that provides habilitation to members who meet an institutional level of care.

This includes services such as teaching components, measurable goals, and there is no time limit on these services.

Some members may also receive transition assistance services and employment services.

Texas Children's Health Plan STAR Kids

MDCP services include:

MDCP refers to the Medically Dependent Children Program which gives services to families caring for children and young adults as an alternative to receiving services in a nursing facility.

- Personal Care Services (PCS) are support services provided to a person eligible for THSteps-CCP services who requires assistance with ADLs or IADLs due to physical, cognitive, or behavioral limitations related to his or her disability or chronic health conditions.
- Private Duty Nursing (PDN) are services provided in an individual's home and are beyond what a certified home health agency can provide.
- Respite care
- Supported employment
- Transition assistance services (TAS)
- Adaptive aids
- Employment assistance (EA)
- Minor home modifications
- Flexible family support services

Keep in mind that the MDCP program is limited to enrollment and annual budget limitations for members based on an Individual Service Plan that is formulated by the service coordinator.

For additional information on these services please refer to Texas Medicaid Provider Procedures Manual.



Texas Children's Health Plan STAR Kids

Behavioral Health Covered Services

Texas Children's Health Plan has a toll-free number for members to use on a 24-hour, 7-day-a-week basis, answered by health professionals who will assist in identifying an appropriate provider for the patient. STAR Kids members may call 1-800-731-8529. (The primary care provider is responsible for maintaining treatment records and obtaining a written medical record release from the member or a parent/legal guardian of the member before records can be released.)

Available behavioral health services include:

- Psychiatric assessment and referral services
- Individual, family, and group counseling
- Acute inpatient hospitalization
- Short-term residential
- Partial hospitalization
- Intensive outpatient/day treatment
- Medication evaluation and monitoring
- Referral for other community services
- Case management
- Off-site service (home-based, school-based, mobile crisis, home health)
- Residential Services

Texas Children's Health Plan is responsible for authorized inpatient hospital services, including services provided in freestanding psychiatric facilities.



Texas Children's Health Plan STAR Kids

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Texas Children's Health Plan 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 and young adults (birth through age 20), Texas Children's Health Plan 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 including supplements and vitamins.

To be reimbursed for DME or other products normally found in a pharmacy for children (under the age of 21 years), a pharmacy must first enroll in our Network by contacting Navitus at 1-866-333-2757 or via e-mail at providerrelations@navitus.com.

Pharmacies will submit pharmacy claims to Navitus. Call Navitus Provider line at 1-866-333-2757 for information about DME and other covered products commonly found in a pharmacy for children (under the age of 21 years).

Pharmacy Benefit Manager (PBM) - Navitus

Navitus Health Solutions is a full-service pharmacy benefit company committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence. It is the elected pharmacy benefit manager (PBM) of Texas Children's Health Plan. The Vendor Drug Program (VDP), defines the Texas Managed Medicaid formulary, including the Preferred Drug List and any clinical edits.

Vendor Drug Program (VDP)

Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for clients enrolled in Medicaid. All fee-for-service outpatient prescription claims are processed through the VDP real-time, point-of-sale system using the latest National Council for Prescription Drug Programs (NCPDP) telecommunication standard format.

The system validates client, pharmacy, prescriber, and product; identifies any prior authorization requirements or other known insurances; and calculates reimbursement. The system responds with information regarding client eligibility, the program's allowed payable amount, applicable prospective drug utilization review messages, and applicable error codes and messages.

Formulary

The Texas Drug Code Formulary covers more than 32,000 line items of drugs including single source and multisource (generic) products. VDP only reimburses pharmacy providers for outpatient prescription drugs.

For questions related to formulary, preferred drug list, billing, prescription overrides, prior authorizations, quantity limit, or formulary exceptions, please call Navitus at 1-866-333-2757 or accessing the Navitus website at www.navitus.com.

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 HPBM's 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

Texas Children’s Health Plan STAR Kids

Process for requesting a Prior Authorization for prescription medications

- Navitus processes Texas Medicaid pharmacy prior authorizations (PA) for Texas Children’s Health Plan
- The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by the Health and Human Services Commission (HHSC)
- Information regarding the formulary and the specific prior authorization criteria can be found at HPBM’s website, ePocrates, and SureScripts for ePrescribing
- Prescribers can access prior authorization forms online via www.navitus.com under the “Prescribers” section or have them faxed by Customer Care to the prescriber’s office
- Medications that require prior authorizations 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 a prior authorization

At that point, the pharmacy should notify the prescriber and the above process should be followed.

STAR Kids Medical Home/Health Home

Texas Children’s Health plan provides access to a Health Home to any Member the health plan determines would most benefit from a Health Home or for any Member who requests a Health Home. A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care. Health Home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services include:

1. Patient self-management education
2. Provider education
3. Patient-centered and family-centered care
4. Evidence-based models and minimum standards of care
5. Patient and family support (including authorized representatives)

Health Home Services may also include:

1. Implementation of interventions that address the continuum of care
2. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact
3. Comprehensive care coordination and health promotion
4. Palliative care options in the event of a life-limiting diagnosis
5. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings
6. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction
7. Referral to community and social support services, if relevant
8. Use of health information technology to link services, as feasible and appropriate

Texas Children's Health Plan STAR Kids

Texas Children's Health Plan STAR Kids Services

Texas Children's Health Plan understands the need to offer additional customized, individual services for our members. The list below illustrates extra care as well as fun activities for our members:

- **Caregiver Respite Care Services** offers eight hours of in-home respite services in addition to the home and community-based services.
- **Additional transportation services** are available to members if transportation is a barrier to attend medical visits. Texas Children's Health Plan will, upon verification of medical appointments, arrange for transportation through taxi voucher or bus. If the member has access to private vehicle transportation, Texas Children's Health Plan may offer a prepaid gasoline card to reimburse for mileage.
- **Sports Team Reimbursement** offers reimbursement for members ages 5 to 20 to any sports programs available in the member's area for up to 4 games per year.
- **Smoking Cessation Benefits** are a value-added service for STAR Kids Members because Texas Children's Health Plan understands the importance of a smoke-free environment for children. Texas Children's Health Plan covers up to \$50 above the basic benefit – for nicotine replacement products including over the counter and prescription items. Health coaching, education and referral to approved programs are offered free of charge to tobacco dependent parents of all members that agree to coaching.
- **Pest Control Services** are offered to select STAR Kids members with asthma.
- **Parent Training** provides accredited parent training seminars on a variety of topics from which parents of STAR Kids members may choose. Topics include caring for children with certain diagnoses, such as ADHD or Autism; navigating special education opportunities and services; and parent training on advocating for children with intellectual or developmental disabilities. Parents may attend any accredited seminar.
- **Sensory-Friendly Movie Events** allow children to enjoy a movie without the expectations of a regular movie theater. Texas Children's Health Plan recognizes that it may be difficult for children with special health care needs to attend a movie in a theater where the expectation is that children remain quiet. A sensory-friendly film provides brighter lighting, lower sound, shorter previews and a welcoming and accepting environment.
- **Post Hospitalization Follow-Up Visit Incentive** gift cards are offered to members for completing a follow-up visit after being hospitalized within 7 to 14 days of discharge.

Long Term Services and Supports (LTSS)

STAR Kids Long Term Services and Supports providers are responsible for (but not limited to) the following:

- Verifying member eligibility
- Obtaining authorizations for services prior to provision of those services
- Initiating services within seven days of authorization for non-Home and Community-based Services (HCBS) STAR Kids Waiver members unless the referring provider or member requests otherwise
- Coordinating Medicaid/Medicare benefits
- MDCP services documentation and reporting requirements
- Notifying Texas Children's Health Plan of changes in a member's physical condition or eligibility
- Partnering with Texas Children's Health Plan Service Coordinator in managing a member's health care
- Managing continuity of care
- Employment Assistance (EA) providers must develop and update quarterly a plan for delivering Employment Assistance Services

Texas Children's Health Plan STAR Kids

- Supported Employment providers must develop and update quarterly a plan for delivering Supported Employment Services
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101 All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Texas Children's Health Plan if a member experiences any of the following:
 - A significant change in the member's physical or mental condition or environment
 - Hospitalization
 - An emergency room visit
 - Two or more missed appointments

Community First Choice

CFC providers must:

- Deliver in accordance with the Member's service plan.
- Maintain current documentation which includes the member's service plan, Intellectual Disability Related Condition (ID/RC) (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- Ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.) (HCS or TxHmL program).
- Ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- Ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline (1-800-647-7418).
- Address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- Not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- Ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- Have the appropriate licensure to deliver the service (CFC ERS).
- Ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured per the CFR §441.565.
- Adhere to the Health Plan's financial accountability standards.

Texas Children's Health Plan STAR Kids

- Prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- Prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.

Behavioral Health Network

Texas Children's Health Plan recognizes that the Behavioral Health diagnoses and level of care needs of our members will fall across a broad continuum. Therefore, our network of Behavioral Health providers includes both Significant Traditional Providers (STPs) as well as specialty Providers able to screen for and provide mental health rehabilitative services and targeted case management services.

Additionally, to support access to quality Behavioral Health care for all members, including members of underserved linguistic or cultural groups, Texas Children's Health Plan's Behavioral Health contracting strategy prioritizes providers with clinical integration of medical and Behavioral Health services and whose mission includes targeting the underserved. Federally Qualified Health Centers (FQHCs) are an important component of Texas Children's Health Plan's medical network and these organizations employ Behavioral Health clinicians as part of their primary care team. Texas Children's Health Plan is committed to providing technical assistance and support for providers interested in integrating care within their clinics as well as supporting expansion of mental health rehabilitation and inpatient services providers within our network.

Our Behavioral Health network includes a variety of providers who care for children and adolescents with severe emotional disturbance (SED).

Mental health rehabilitative services to youth with SED within their service areas and are committed to partnering to ensure STAR Kids youth have access to the right services at the time they are needed.

The Local Mental Health Authorities specialize in treating children and adolescents with a dual diagnosis of Mental Health and Substance Abuse. We also have a number of independent providers in the Behavioral Health network who treat children and adolescents with a dual diagnosis.

Primary Care Provider Requirements for Behavioral Health

Primary care providers must screen, evaluate, refer, and/or treat any behavioral health problems and disorders for Texas Children's Health Plan members. The primary care provider may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues and excludes STAR Kids with dual eligibility.

Texas Children's Health Plan has a comprehensive network of behavioral health service providers for the treatment of mental health and drug and alcohol abuse issues. Documentation in both the physical and behavioral health records of integration of clinical care should include a written release of information which will permit specific information sharing between providers.

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)

Mental Health Rehabilitative (MHR) Services are those age-appropriate services determined by HHSC and Federally approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the Member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the Member's rehabilitation plan.

Mental Health Targeted Case Management (TCM) means services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these services based on a standardized assessment (the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA) and other diagnostic criteria used to establish medical necessity.

Texas Children's Health Plan STAR Kids

Texas Children's Health Plan coordinates with a provider of mental health rehabilitation and mental health targeted case management to determine whether the member meets an IMD level of care. Texas Children's Health Plan develops a service plan identifying the needed Community First Choice services, as well as any additional services the member may benefit from, including the MDCP waiver.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a common behavioral disorder that begins in early childhood and can continue through adolescence and into adulthood. ADHD makes it difficult for a child to focus and pay attention. Some children may be hyperactive and have trouble being patient or sitting still. For those experiencing ADHD, levels of inattention, hyperactivity, and impulsive behaviors are greater than for other children in their age group. ADHD can make it hard for a child to do well in school, at home, or in the community. Adults may have difficulty staying on task at work or following instruction. There are effective ways of treating ADHD. Whether a child or adult, often individuals with ADHD respond to cognitive behavioral therapy. Furthermore, provider education and coaching of parents/guardians with an ADHD child or adolescent has shown to greatly improve symptoms by teaching ways to improve social structure and support system necessary for success. In some cases, along with counseling and education, medication may be needed to help a person with ADHD.

A qualified in-network physician can help make that determination as well as recommend which medication would be best to help decrease the presenting symptoms. Once a medication is started, regular visits to the prescribing physician are necessary to monitor effectiveness and possible side effects. Lastly, a prescribed medication should never be stopped without first consulting the physician. The interventions discussed above are services covered by Texas Children's Health Plan and are readily available to those individuals who are experiencing ADHD. If ADHD is being considered, the best place to start is with the primary care physician.

ADHD Maintenance Follow Up

Children, ages 6 to 12, who received an initial prescription for ADHD medication must:

- Receive at least one follow-up visit with a prescribing authority within 30 days of initiation of medication
- Remain on the medication for at least 210 days and, in addition to the visit in the initiation phase, have at least two more follow-up visits between four weeks and nine months.

Self-Referral

Texas Children's Health Plan members may self-refer to any in-network behavioral health provider. Please contact Texas Children's Health Plan for additional information at 832-828-1004 or toll free at 877-213-5508.

Ensuring All Children Receive Appropriate Services; Continuity of Care

Frew Background – Frew vs. Traylor

Texas House and Senate leaders announced an agreement in principle to settle finally the 14-year-old Medicaid lawsuit known as Frew vs. Traylor. The class action lawsuit, originally filed in 1993, alleged numerous, serious failings in the state's efforts to ensure all children enrolled in Medicaid were receiving appropriate preventive and specialty care services available to them via the federally-required Early Periodic Screening Diagnosis and Treatment Act (EPSDT). These services are known in Texas as "Texas Health Steps." In 1995, the state and plaintiffs negotiated a consent decree to resolve the case. However, within a few years the state challenged plaintiffs' right to enforce the decree, compelling the case back to the federal courts, including two state appeals to the Supreme Court. At each juncture, the federal courts sided with the plaintiffs. The settlement was announced just days prior to the case returning to Federal District Judge William Wayne Justice to rule on the final Corrective Action Plans.

On April 9, Judge Justice reviewed the proposed agreement, some elements of which will continue to be negotiated over the next several weeks. In June, Judge Justice will again review the agreement and the funding that accompanies it. The agreement is subject to his final approval and oversight.

Texas Children’s Health Plan STAR Kids

Alberto N First Partial Settlement Agreement

The Alberto N First Partial Settlement Agreement requires Texas Children’s Health Plan to notify members when reducing, denying, or terminating a requested Medicaid service on the basis that the service is not medically necessary or federal financial participation is not available and when Texas Children’s Health Plan receives incomplete prior authorization requests. Notices must substantially conform to the sample notices in the UMCM and must be written at a sixth-grade reading level with the exception of citations, medical terms, policy, or law.

Alberto N Second Partial Settlement Agreement

The Alberto N Second Partial Settlement Agreement requires that Texas Children’s Health Plan send notification to members regarding denied nursing services and denied private duty nursing services.

Texas Health Steps Benefits

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 the age of five days old. 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 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

The Required Elements of a Check-Up

Providers are expected to comply with federal and state mandated requirements for documentation in order for the checkup to be considered complete. Texas Children’s Health Plan will conduct random audits to ensure compliance, and failure to accurately complete documentation will require a corrective action plan.

- **Comprehensive health and developmental history, including physical and mental health development**—A complete history includes family and personal medical history along with nutritional screening, developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
- **Comprehensive unclothed physical examination**—A complete exam includes the recording of measurements and percentiles to document growth and development including length or height and weight (0-20 years), fronto-occipital circumference (0-2 years), body mass index (2-20 years) and blood pressure (3-20 years). Oral health screening and hearing and vision screening are also required components of the physical exam.
- **Immunizations appropriate for age and health history**—Immunization status must be screened at each medical checkup and necessary vaccines must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.

Texas Children's Health Plan STAR Kids

- **Laboratory tests appropriate for age and risk, including lead toxicity at specific federally mandated ages**–Required age based laboratory screenings include newborn screening and anemia and lead screening. Risk-based lab screenings include testing for hyperlipidemia, diabetes, and sexually transmitted diseases including HIV, syphilis and gonorrhea/chlamydia.
- **Health education including anticipatory guidance**–Anticipatory guidance is a federally mandated component of the medical checkup and health education and counseling is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
- **Dental referral**–Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Missed Appointments Assistance and Referrals

The purpose of the THSteps Outreach & Informing Service is to expand awareness of existing medical, dental, and case management services, including missed appointment referral services. For information, call 1-877-THSteps (847-8377).

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.

THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

		COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE																												
		DEVELOPMENTAL SURVEILLANCE					MEASUREMENTS					VISION		HEARING		LABORATORY TESTS					Health Education/Anticipatory Guidance									
		History	Nutritional Screening	Review of Milestones	ASQ, ASQ:SE, or PEDS	M-CHAT or M-CHAT-R/FTM	Mental Health: Psychosocial/Behavioral Health Screening	TB Questionnaire with Skin Test If Risk Identified	Unclothed Physical Examination	Critical Congenital Heart Defect Screening	Length	Height	Weight	BMI	Fronto-Occipital Circumference	Blood Pressure	Visual Acuity	Subjective Vision	Newborn Hearing Test (OAE or ABR)	Audiometric Screening	Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	Newborn Screening Panel	Blood Lead Screening	Anemia	Dyslipidemia	Type 2 Diabetes	Health Education/Anticipatory Guidance	
AGE	Newborn	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
	D/C to 5 days	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
	2 weeks	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
	Months	2	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
		4	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
		6	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
		9	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
		12	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
		15	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
	Years	18	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
24		█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
30		█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
3		█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
4		█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
5		█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
6	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
7	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
8	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
9	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	
10	█	█	█			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	

LEGEND OF SYMBOLS

- █ Mandatory at this age.
- █ If a component is not completed at the required age, it is mandatory for the provider to complete at the first opportunity if age-appropriate.
- █ When symbols appear at the same age for developmental, mental health, vision, or hearing screening, perform the most appropriate-level screen.
- █ Risk-based.

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: www.dshs.state.tx.us/thsteps/providers_components.shtm. For free online provider education: txhealthsteps.com.

Texas Children's Health Plan STAR Kids

THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

		COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE																				
		* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPM) for further detail at: http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx . Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm .																				
AGE	Years	History	Nutritional Screening	Mental Health: Psychosocial/Behavioral Health Screening	PSC-35, Y-PSC, PHQ-9, or CRAFFT	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	MEASUREMENTS				VISION		HEARING		Dental Referral	Screen/Administer Immunizations According to ACP Guidelines	LABORATORY TESTS				Health Education/Anticipatory Guidance
								Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing			Dyslipidemia	Type 2 Diabetes	STD/STI Screening	HW Test	
11		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
12		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
13		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
14		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
15		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
16		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
17		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
18		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
19		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
20		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

LEGEND OF SYMBOLS	
■	Mandatory at this age.
■	If a component is not completed at the required age, it is mandatory for the provider to complete at the first opportunity if age-appropriate.
■	When symbols appear at the same age for developmental, mental health, vision, or hearing screening, perform the most appropriate-level screen.
■	Risk-based.

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: www.dshs.state.tx.us/thsteps/providers_components.shtm. For free online provider education: txhealthsteps.com.

E03-13634 February 1,2017



STAR Kids Service Coordinator

The service coordinator is the central point of contact between Texas Children's Health Plan, a member, providers and family members. The service coordinator identifies the member's needs, coordinates with other service providers and develops a complete individual service plan (ISP) to provide the following:

- Nursing facility care services
- Acute care services
- Behavioral health services
- Environmental care services
- Functional care services
- Home and community-based care services

The Service coordinator engages as an advocate and intervenes on behalf of the member, if permitted. This includes advocacy in school meetings and collaboration with other entities and individuals involved with a member's total program of care. As part of this process, the service coordinator facilitates an ongoing exchange of information with individuals or entities responsible for coordinating, implementing and monitoring HCBS Waiver services. This includes sharing the initial ISP and any changes to the ISP as required. Further, the service coordinator will determine the appropriate re-assessment schedule based on the needs of the specific waiver program requiring re-certification.

Texas Children's Health Plan furnishes a named Service Coordinator to a member when it is determined, through an assessment of the member's health and support needs, that one is required. Texas Children's Health Plan also furnishes a named Service Coordinator to all members who request one. Texas Children's Health Plan assigns EVERY member to a Service Coordinator for accountability of member engagement and monitoring of progress on ISP goals.

Texas Children's Health Plan STAR Kids

The following is provided for all STAR Kids members:

- A description of service coordination
- A phone number to contact if the member needs service coordination or is experiencing problems with service coordination
- The name of their Service Coordinator, if applicable
- The phone number and e-mail address of their named Service Coordinator. If the named Service Coordinator changes, Texas Children's Health Plan notifies members within five business days of the name and phone number of the new Service Coordinator. Within the same time period, Texas Children's Health Plan also posts the new Service Coordinator's information on the portal or website members use to obtain plan information. If the member is in a nursing facility when the change occurs, the nursing facility is notified of the new Service Coordinator's contact information within five days.

When Providers should contact a Service Coordinator:

1. To request additional services
2. To assist in helping with the LAR (legally authorized representative) with an explanation or information
3. Or any other reason the member may need assistance with care

The number is 1-800-659-5764.

The provider would:

1. Enter member ID # or press#
2. Select option 3 to speak with a service coordinator.

Service Coordination Levels of Care

The Texas Children's Health Plan service coordination level is based on assessment information provided by the member, the member's legally authorized representative (LAR) and service providers.

Level 1 Members

All Level 1 Members must receive a minimum of four face-to-face Service Coordination contacts annually, in addition to a monthly phone call, unless otherwise requested by the Member/LAR. Texas Children's Health Plan provides a Level 1 Member with a named Service Coordinator. Members also receive contact from a Service Coordinator within 30 days of the initial Individual Service Plan (ISP) or any change in the ISP to monitor implementation of that plan.

Level 2 members

All Level 2 Members must receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually unless otherwise requested by the Member. Texas Children's Health Plan provides a Level 2 Member with a named Service Coordinator. Members also receive contact from a Service Coordinator within 30 days of the initial Individual Service Plan (ISP) or any change in the ISP to monitor implementation of that plan.

Level 3 Members

All Level 3 Members must receive a minimum of one face-to-face visit annually and at least three telephonic service coordination outreach contacts yearly. Texas Children's Health Plan will assign every Level 3 Member a Service Coordinator as the responsible party for Member engagement. Members also receive contact from a Service Coordinator within 30 days of the initial Individual Service Plan (ISP) or any change in the ISP to monitor implementation of that plan.

Discharge Planning

In support of successful discharge planning to transition a member back to the community, the Texas Children's Health Plan Service Coordinator works with the member's PCP/admitting physician, the hospital/inpatient psychiatric facility discharge planner(s), the attending physician, the member and the member's family to assess and plan for the member's discharge. The discharge planning process is initiated at the notice of inpatient admission. Texas Children's Health Plan's Utilization Management (UM) specialists identify the members' needs related to acute inpatient episodes of care, collaborating with the facility case managers to proactively identify setting, service and equipment requirements beginning on the day of admission. The UM specialists notifies the service Coordinators of admission to initiate the process.

Upon receipt of notice of a Member's discharge from an inpatient psychiatric facility, a Service Coordinator must contact the Member within 1 Business Day. Discharge planning includes establishing appropriate service authorizations. When long-term care is needed, the MCO must ensure that the Member's discharge plan includes arrangements for receiving Community-Based Services as appropriate.

Texas Children's Health Plan STAR Kids

The Service Coordinator informs the Member, the Member's family of all service options available to meet the Member's needs in the community. Texas Children's Health Plan is responsible for timely access to Service Coordination to arrange for Medically Necessary or Functionally Necessary PCS or Private Duty Nursing Services immediately upon the Member's transition from a Nursing Facility or ICF/IID to the community.

Adult Transition Planning

STAR Kids Only

Texas Children's Health Plan will help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Texas Children's Health Plan is responsible for conducting ongoing transition planning that begins when the Member turns 15 years of age.

The health plan will provide transition planning services as a team approach, through the named Service Coordinator and a transition specialist. A Transition Specialist is an employee of the Health Plan dedicated to counseling and educating Members, and others in their support network, about considerations and resources for transitioning out of STAR Kids. Transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model with continuous provision of services.
2. Prior to the age of 10, the Health Plan must inform the Member and the Member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the Health Plan must regularly update the ISP with transition goals.
4. Health Plan is responsible for coordinating with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, the Health Plan may collaborate with the Member's school on the Individual Education Plan (IEP) to ensure consistency of goals.
6. The Health Plan promotes Health and wellness education to assist the Member with Self-Management.
7. The Health Plan assists with the identification of additional resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. The Health Plan will provide assistance applying for community services and other supports under the STAR+PLUS program, after the Member's 21st birthday.
9. The Health Plan will provide assistance with identifying adult healthcare providers.

Prior Authorization

How do I obtain a Prior Authorization?

Authorization requests may be submitted to Texas Children's Health Plan by faxing the authorization form and required documentation to 832-825-8760 or calling 832-828-1004, option 5. Behavioral Health authorizations may be sent to Behavioral Health toll-free Fax: 1-844-291-7505.

When a UM Specialist is unable to approve the requested service based on Texas Children's Health Plan criteria, the Medical Director/Associate Medical Director/Physician Reviewer will review the authorization request and any available clinical information, prior to issuance of any denial based on lack of medical necessity. Before a denial is issued by Texas Children's Health Plan regarding the medical necessity or appropriateness, or the experimental or investigational nature, of a healthcare service, Texas Children's Health Plan provides the requesting provider a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis prior to the adverse determination. A decision to deny a service authorization based on medical necessity can only be made by a physician.

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.

Texas Children's Health Plan has developed Utilization Management guidelines that are objective and based on Medical evidence to serve as criteria for the determination of medical necessity for services that require prior authorization. The goal of our UM guidelines is to encourage the highest quality care from the right provider in the right setting. To access the Guidelines providers may log in to the provider portal at www.tchp.us/providers or contact Texas Children's Health Plan Provider Relations department at 832-828-1008 or toll-free at 1-800-731-8527.

If a request for services is denied by Texas Children's Health Plan, the ordering provider, rendering provider and member will receive a letter indicating the reason why services are being denied. The member, member designee, practitioner or provider has the right to appeal a denial of services. The appeal process is delineated in the denial letter that is sent.

Texas Children's Health Plan STAR Kids

Prior Authorization Requirements (effective date: April 1, 2017)

Below is a list of updated changes to the prior authorization list found in your provider manual and on the Texas Children's Health Plan website. These medical services require prior authorization. A check mark indicates the medical service is a covered benefit if medical necessity criteria are met and with prior authorization. All services will be subject to benefit limitations.

Please be sure to update your material by printing this memo and placing it in the appropriate section.

Medical Services	CHIP	CHIP Perinate	STAR	STAR Kids	STAR Kids MDCP
Adaptive Aids					✓
Adult Day Care/ Day Activity and Health Services (more than 1 unit per day)				✓	✓
Ambulance (non-emergent transport)	✓	✓	✓	✓	✓
Augmentative Communication Device	✓		✓	✓	✓
Baclofen pump	✓		✓	✓	✓
Bariatric Surgery	✓		✓	✓	✓
Botulinum Toxin Injections	✓		✓	✓	✓
Chemotherapy non-FDA approved	✓		✓	✓	✓
Circumcision greater than 1 year of age	✓		✓	✓	✓
Cosmetic Surgery	✓		✓	✓	✓
Cranial Molding Orthosis (Helmets)	✓		✓	✓	✓
Employment Assistance					✓
Emergency Response Services (Community First Choice)				✓	✓
Flexible Family Support Services					✓
Financial Management Services				✓	✓
Gait Trainers, Standers, Walkers	✓		✓	✓	✓
Genetic Testing	✓	✓	✓	✓	✓
Habilitation (Community First Choice)				✓	✓
Home Health Care	✓		✓	✓	✓
Home Modifications Maintenance					✓
Hospital grade Blood Pressure Monitors for home use	✓		✓	✓	✓
Hospital Beds and accessories	✓		✓	✓	✓
Hospital Inpatient care	✓		✓	✓	✓
Implantable Hearing Device	✓		✓	✓	✓
Magnetoencephalography (MEG)	✓		✓	✓	✓
Minor Home Modifications					✓
Nutritional Supplements	✓		✓	✓	✓
Oral Surgery	✓		✓	✓	✓
Out of Network Services (excluding emergency services, family planning for STAR/STAR Kids only, and well child exams for all plans)	✓	✓	✓	✓	✓
Personal Care Services or Personal Assistance (Community First Choice)				✓	✓

Texas Children's Health Plan STAR Kids

Medical Services	CHIP	CHIP Perinate	STAR	STAR Kids	STAR Kids MDCP
PET Scans	✓		✓	✓	✓
Positive Airway Pressure Device (CPAP/BiPAP)	✓		✓	✓	✓
Prescribed Pediatric Extended Care Centers			✓	✓	✓
Private Duty Nursing in Home	✓		✓	✓	✓
Progesterone Therapy	✓	✓	✓	✓	✓
Prosthetics	✓		✓	✓	✓
Respite Care					✓
Skilled Nursing facility	✓		✓	✓	✓
Sleep Studies in Children	✓		✓	✓	✓
SPECT Scans	✓		✓	✓	✓
Spinraza (Nusinersen) Infusion	✓		✓	✓	✓
Supported Employment					✓
Therapy-Occupational (excluding Early Childhood Intervention (ECI) Programs, Reevaluations and Acute Therapy Evaluations with the AT Modifier)	✓		✓	✓	✓
Therapy-Physical (excluding Early Childhood Intervention (ECI) Programs, Reevaluations and Acute Therapy Evaluations with the AT Modifier)	✓		✓	✓	✓
Therapy-Speech (excluding Early Childhood Intervention (ECI) Programs, Reevaluations)	✓		✓	✓	✓
Therapeutic and Reconstructive Breast Procedures (including breast prosthesis)	✓		✓	✓	✓
TMJ diagnosis and treatment	✓		✓	✓	✓
Transition Assistance Services					✓
Transplant Evaluation	✓		✓	✓	✓
Vision Care, medically necessary	✓		✓	✓	✓
Wheelchairs and accessories	✓		✓	✓	✓
Behavioral Health Services	CHIP	CHIP Perinate	STAR	STAR Kids	STAR Kids MDCP
Inpatient Care	✓		✓	✓	✓
Intensive Outpatient Treatment (Chemical Dependency Treatment Facility)	✓		✓	✓	✓
Mental Health Rehabilitation Services and Targeted Case Management			✓	✓	
Neuropsychological Testing	✓		✓	✓	✓
Out of Network Services	✓		✓	✓	✓
Outpatient Psychotherapy Visits Greater than 30 (Per Calendar Year)	✓		✓	✓	✓
Partial Hospitalization (Mental Health)	✓		✓	✓	✓
Psychological Testing (excluding initial evaluation)	✓		✓	✓	✓
Residential Treatment Facility	✓		✓	✓	✓
Skills Training and Development	✓		✓	✓	
Substance Use Disorder Treatment (excluding evaluation)	✓		✓	✓	✓

Texas Children's Health Plan STAR Kids

Out-of-Network Referrals

The primary care provider may request out-of-network referrals for services which cannot be provided within the Texas Children's Health Plan network. Specialists must consult with the primary care provider in a timely manner if out-of-network specialty referrals are needed. All providers who deliver care to STAR Kids members must be an attested Texas Medicaid Provider.

The primary care provider submits an authorization form by calling 832-828-1004, option 5 or toll free at 1-877-213-5508 or faxing to 832-825-8760. Texas Children's Health Plan's Medical Director or Utilization Management Program staff will review the clinical information and either authorize or deny the services according to the availability of such services within the Texas Children's Health Plan network and presenting pertinent clinical information. All denials are the responsibility of the Medical Director.

Continuity of Care for STAR Kids

Texas Children's Health Plan has revised its policies regarding continuity of care for STAR Kids.

Texas Children's Health Plan does not require approval, referral, or authorization to in-network physician specialists, including behavioral health care, women's health care, or urgent care. From November 1, 2016 through October 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist either in or out of the service area. The out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan.

While Members may seek physician specialist services from in-network providers without Texas Children's Health Plan approval, we do encourage Members to engage their primary care provider and medical home first, to ensure:

- The physician specialist is the right one for the illness or condition.
- The physician specialist does not require information from the primary care provider.
- The information from the visit is communicated back to the primary care provider.

Below are specific examples:

1. If the Member is seeking services from a new physician specialist with no existing relationship, Texas Children's Health Plan does not require approval, referral, or authorization for an in-network physician specialist. From November 1, 2016 through October 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist. An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan. We may require an authorization for some services that the physician specialist may perform, such as genetic or psychological testing.
2. If the Member is seeking urgent care from a new physician specialist, Texas Children's Health Plan does not require approval, referral, or authorization for an in-network physician specialist. From November 1, 2016 through October 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist. An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan. We do encourage Member's to contact their primary care provider first, to:
 - Make sure it is appropriate to wait.
 - Monitor that the illness does not turn into an emergency.
 - Facilitate the appointment.

If a Member is seeking emergency services from a new physician specialist, we do not require an approval, referral, or authorization if the services are a covered benefit and are performed by a provider that is qualified to furnish the services and that are needed to evaluate or stabilize the emergency medical condition.

3. If the Member is seeking services from a physician specialist with an existing relationship, Texas Children's Health Plan does not require approval, referral, or authorization for an in-network physician specialist. From November 1, 2016 through October 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist. An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan. We may require an authorization for some services that the physician specialist may perform, such as genetic or psychological testing.

Provider Responsibilities

Texas Children’s Health Plan’s participating providers play a vital role in serving STAR Kids members. Accessibility, along with accurate provider directories, whether print or online, is important for quality of care and services. Updating demographic information, appointment and after hours’ accessibility are essential to maintaining a robust network.

Appointment Accessibility

Providers must comply with the following appointment accessibility requirements.

Service	Texas Children’s Health Plan Response Standard
Emergency	Upon member presentation at service delivery site, including non-network and out-of-area facilities
Urgent care, including urgent specialty care and behavioral health	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 21 days of request
Initial outpatient behavioral health visit	Provided within 14 days of request
Routine prenatal care	Provided within 14 days of request or immediately if an emergency exists
Prenatal care for high-risk pregnancies or new members in third trimester	Appointment offered within 5 days, or immediately if an emergency exists
Preventive health care services for children	Offered in accordance with Texas Health Steps Periodicity Schedule
Newborns	In no case later than 14 days of enrollment of Texas Health Steps Periodicity Schedule
Existing member overs 36 months annual checkup within 364 days of birthday	Provided within 90 days of request
Initial outpatient behavioral health visits upon discharge from an inpatient psychiatrist setting	Provided within 7 days of request
New member	Provided within 90 days of request
Community-based services for Non-MDCP STAR Kids waiver members	Initiated 7 days from the date the MCO authorizes services unless the referring provider or member states otherwise

Acceptable After-hours Coverage

1. The office telephone is answered after-hours by an answering service, which meets language requirements of the major population groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. The office telephone 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 telephone. Another recording is not acceptable.
3. The office telephone is transferred after office hours to another location where someone will answer the telephone. That person must be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable After-hours Coverage

1. The office telephone is only answered during office hours.
2. The office telephone is answered after-hours by a recording that tells patients to leave a message.
3. The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

Provider Responsibilities

Updating Demographic Information

Demographic changes must be sent in writing to Texas Children's Health Plan within a minimum of 30 calendar days. Changes not received in writing are not valid. Texas Children's Health Plan and its designated claims administrator are not responsible for potential claims processing and payment errors due to failure to update information. Notification of change should be made to Texas Children's Health Plan Provider and Care Coordination at the following email address tchpdemographicupdat@texaschildrens.org or by fax 832-825-8750.

Examples of demographic changes include:

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

Network providers must also notify Health and Human Services Commission's administrative services contractor of any demographic changes.

Mandatory Challenge Survey

Texas Children's Health Plan has developed and implemented a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. By designing a periodic, randomized survey, a provider is required to provide input before accessing provider portal functionalities. The challenge survey includes verification of the following elements:

- Provider Name
- Address
- Phone Number
- Office Hours
- Days of Operation
- Practice Limitations
- Languages Spoken
- Provider Type / Provider Specialty
- Pediatric Services
- Wait Times for Appointment
- Closed or Open Panel (PCPs only)
- Texas Health Steps Provider (PCP only)

Texas Children's Health Plan enforces access and other network standards required by the contract and takes appropriate action with providers whose performance is determined by the health plan to be out of compliance. In addition, providers and staff are responsible for understanding the aforementioned products and terms. With increased oversight by HHSC, it is highly likely secret shoppers will contact provider offices to assess their comprehension.

Provider Responsibilities

Online Directory

Texas Children's Health Plan members can access the Find a Doctor tool, a current online search directory, at www.tchp.us. A search can be performed in the following ways:

- Product type
- Provider type or speciality
- Area of interest
- Last name, gender, and hospital affiliations
- Zip code, city, and distance

Texas Children's Health Plan Web Site

Texas Children's Health Plan offers resources and tools to better serve provider at www.tchp.us under the **FOR PROVIDER** tab. Resources include the provider portal, provider manual, Quick Reference Guide, provider news–The Checkup, and clinical practice guidelines.

The provider portal login can be found in this section under PROVIDER TOUCHPOINT. A provider and/or a provider's staff member can request a user name and password for access to the portal. Once logged in, viewable services include:

- Claims
- Eligibility
- Authorizations

Other key information that can be found on the portal include:

- Asthma High Risk Report and EPSDT Non-compliant List – two of many custom reports the health plan provides to practices based on population data from claims submission
- Provider Manual, an HHSC approved resource for provider practices
- Quick Reference Guide that includes:
 - Phone and fax numbers for Texas Children's Health Plan's departments
 - A list of current services requiring authorizations
 - Fraud and Abuse Hotline information
 - Claims filing and electronic claims submission

TheCheckup is a provider's entryway to provider communication. A provider can find the latest health plan news on the web site such as:

- Announcements
- Medical Director blog
- Videos
- Provider Events
- Continuing Medical Education events
- Clinical practice guidelines

Reporting Fraud, Waste, or Abuse

Do you want to report fraud, waste or abuse?

Texas Children's Health Plan's Special Investigative Unit (SIU) committee is charged with reviewing potential fraud, waste and abuse cases; making determinations on investigation referrals to the State; placing providers on prepayment review; referring providers for education and possible recoupment and sending cases for outside analysis by a consultant or physician peer review.

Who could commit fraud, waste or abuse?

- a doctor
- a dentist
- a pharmacist at a drug store
- other health care providers

Examples of fraud, waste and abuse:

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> and follow the instructions under the "Report Fraud" button. ; or
- You can report directly to the Health Plan:
 - By phone hotline: 832-828-1320
 - By fax: 832-825-8722
 - By email: FraudandAbuse@TCHP.us
 - By mail:

**Texas Children's Health Plan
Fraud & Abuse Investigation
PO Box 301011
Houston, TX 77230-1011**

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Reporting Fraud, Waste, or Abuse

When reporting about someone who gets benefits, include:

- The person's name.
- The person's date of birth, Social Security number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse, or fraud.

Report suspected Abuse, Neglect, or Exploitation (ANE):

Texas Children's Health Plan and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include Texas Children's Health Plan and provider responsibilities related to identification and reporting of ANE. Additional state laws related to Texas Children's Health Plan and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both Department of Family and Protective Services (DFPS) and DADS;
- Adult day care centers; or
- Licensed adult foster care providers.

Contact DADS at 1-800-647-7418.

Reporting Fraud, Waste, or Abuse

Cultural Awareness

In the interest of providing the best care possible to our multi-cultural Texas Children's Health Plan members, we invite our network providers to visit The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) Web site to learn best practices for promoting culturally competent health care.

You can access the training here: <https://cccm.thinkculturalhealth.hhs.gov/>

Texas Children's Health Plan's Quality Assurance and Performance Improvement Plan

Texas Children's Health Plan is a National Committee for Quality Assurance (NCQA) certified health plan, and providers are expected to use best practice guidelines to meet Health Effectiveness Data and Information Set (HEDIS) metrics.

- Providers who appropriately follow and comply with evidence-based guidelines promoting healthcare coordination, and demonstrate continued excellence or significant performance improvement over time are rewarded through our Texas Children's Health Plan Quality Award program and our Provider Incentive Program (PIP). The Quality Awards are Gold, Silver or Bronze based on the number of quality measures in which the provider excels.
- Supported practices will be practices throughout the Texas Children's Health Plan service areas that have demonstrated an interest in providing a Health Home for children with disabilities. These are practices that agree to provide specialized patient education, evidence-based standards of care, comprehensive care coordination and health promotion, post-discharge follow-up care, patient and family supports, participation in quality improvement processes, and referrals to community resources. Texas Children's Health Plan will assist the practices in medical home assessment and practice transformation and other enhancements, such as "just-in-time" access to clinical experts in complex care, dedicated Service Coordinator and continuing education credits.

Billing and Claims Administration

Claims Filing

Texas Children's Health Plan is in compliance with HIPAA EDI requirements for all electronic transactions. For additional assistance, please call Texas Children's Health Plan Provider Care and Coordination at 832-828-1008 or toll-free 1-800-731-8527.

Please submit claims for the following services to:

Texas Children's Health Plan
PO Box 300286
Houston, TX 77230-0286

- Acute care claims for all STAR Kids Members.
- LTSS services for MDCP STAR Kids Members.

Claims for the following LTSS (Long-Term Services and Supports) services are available based on the waiver programs listed below. Claims for these services will continue to be submitted to the individual waiver program.

Long-Term Services and Supports (LTSS) 1915(c) waivers

CLASS Services

Adaptive Aids
Employment Assistance
Financial Management Services
Minor home modification
Respite
Supported Employment
Auditory integration therapy
Continued family services
Support family services
Prevocational habilitation

DBMD Services

Adaptive Aids
Employment Assistance
Financial Management Services
Minor home modification
Respite
Supported Employment
Chore
Intervener
Orientation/mobility
Residential services

HCS Services

Adaptive Aids
Employment Assistance
Financial Management Services
Minor home modification
Respite
Supported Employment
Residential services

TxHmL Services

Adaptive Aids
Employment Assistance
Financial Management Services
Minor home modification
Respite
Supported Employment
Community support services

YES Services

Adaptive Aids
Employment Assistance
Minor home modification
Respite
Supported Employment
Family supports

Non-medical transportation
Paraprofessional services
Pre-engagement services
Specialized therapies
Supportive family-based alternatives
Transitional services

Long-Term Services and Supports (LTSS) not covered by Texas Children's Health Plan

- a) Texas Children's Health Plan is not responsible for providing payments to a Nursing Facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities or other related condition (ICF/IID), but will provide Acute Care and Service Coordination to a Member residing in a Nursing Facility or an ICF/IID if the services are not provided through the Nursing Facility or ICF/IID as part of the daily rate.
- b) If a Texas Children's Health Plan member changes MCOs prior to the delivery of their custom DME and augmentative devices, with the appropriate authorization the new MCO will be responsible for the claim. TCHP will be responsible for previously authorized custom DME and augmentative devices authorized by another MCO when that member becomes a TCHP member if the delivery occurs after the new enrollment with TCHP. In cases where TCHP may have denied a custom DME and augmentative device and a State Fair Hearing Officer reverses the decision, TCHP will be responsible for the cost of the custom DME service/equipment from the date of original denial.
- c) If a Texas Children's Health Plan MDCP STAR Kids Waver member changes MCOs before completion of a minor home modification, Texas Children's Health Plan will cover the minor home modifications. All other services will be covered by the new MCO.

Billing and Claims Administration

Clean Claims Payment for Professional and Institutional Claim Submission

A clean claim is defined as a claim submitted by a physician or provider for medical care or health care services rendered to a member, with the data necessary for the Health Plan to adjudicate and accurately report the claims. A clean claim must meet all requirements for accurate and complete data as defined in the 837 transaction guide.

Once a clean claim is received, Texas Children's Health Plan is required, within the 30-day claim payment period to:

- Pay the claim in accordance with the rate agreed to in your provider contract, or
- Deny the entire claim, or part of the claim, and notify you why the claim or part of the claim was not paid.

All clean claims submitted to Texas Children's Health Plan will be adjudicated (paid or denied) within 30 days of receipt. A provider will be notified in writing if additional information is needed to process a claim. If a clean claim is not adjudicated within 30 days of receipt, Texas Children's Health Plan is responsible for paying a provider interest at a rate of 1.5 percent per month (18 percent annually) for each month or portion of the month that the claim goes unadjudicated.

Claims submitted by providers who are under investigation, have been excluded or suspended from state programs for fraud and abuse will not be considered for payment.

Clean Claims Payment on Pharmacy Claim Submission

Texas Children's Health Plan must process claims in accordance with "Pharmacy Claims Manual," and Texas Insurance Code § 843.339. This law requires the Health Plan to pay clean claims that are submitted electronically no later than 18 days after adjudication, and no later than 21 days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with regarding payment of out-of-network pharmacy claims.

Time Limit for Submission of Claims

A provider must file a claim with Texas Children's Health Plan within 95 days from the date of service. If a claim is not received by Texas Children's Health Plan within 95 days, the claim will be denied.

If the provider files with the wrong plan within the 95-day submission requirement (e.g. State Claims Administrator but not with Texas Children's Health Plan) and produces documentation to that effect, Texas Children's Health Plan must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with Texas Children's Health Plan within 95 days of the date on the Remittance & Status (R&S) from the other (wrong) carrier.

When a service is billed to a third-party insurance resource other than Texas Children's Health Plan, the claim must be re-filed and received by Texas Children's Health Plan within 95 days from the date of disposition by the other insurance resource. Texas Children's Health Plan will determine, as part of its provider claims filing requirements, the documentation required when a provider re-files these types of claims.

All Claims Appeals must be filed within 120 days from the date of denial for reconsideration. When filing and appeal, please attach documentation supporting your position. A Medical Necessity Appeal must be filed within 30 days of receipt of the denial notice.

Billing and Claims Administration

LTSS Billing Procedures

Texas Children's Health Plan (Health Plan) must require all Providers rendering Long-Term Services and Support (LTSS), with the exception of Atypical Providers, may use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing.

Providers using the Paper CMS 1500

- Providers billing on paper will provide complete information about the service event and will use the State Assigned Provider Identification (ID) to represent the Provider(s) involved in the service event. The Provider ID (Billing and/or Rendering) will be located in Block 33 on the paper form.
 - » If the Billing Provider and the Rendering Provider are the same, then the State Assigned Provider ID will be populated in Block 33.
 - » If the Rendering Provider is different than the Billing Provider, then the Billing Provider State Assigned Provider ID will be populated in Block 33, and the Rendering Provider State Assigned Provider ID will be populated in Block 24K.
 - » Under specific scenarios the additional usage of Block 17a (Referring Provider (Optional)) and Block 24k can be used to report additional information on Providers that are involved in the service event.

Providers using the Electronic HIPAA 837

- Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the Provider(s) involved in the service event.

Atypical Providers

- Atypical Providers will submit appropriate documentation to the Health Plan. Please refer to the HIPAA-compliant 837 Professional Combined Implementation Guide and the 837 Professional Companion Guide for further information.

Providers

- LTSS Providers must use the "designated position" of the modifiers as indicated on the Matrix when filing claims.

Nursing Facilities

- Nursing Facilities services pertaining to a member entering a Nursing Facility will be filed (paper or electronic) through the State's Claims Administrator under Traditional Medicaid (Fee for Service) following the claims submission guidelines applicable to Traditional Medicaid billing.
- Nursing Facilities services that do not involve a member entering a Nursing Facility (i.e. Respite Care) will conform to normal LTSS billing procedures.

Billing and Claims Administration

Texas Children's Health Plan Services

Adult Day Care

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Adult Day Care	S5101					3-6 Hours = 1 unit, over 6 Hours = 2 units

Community First Choice - Attendant Care Only (CFC-PCS)

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
CFC PCS Attendant Care Only - Agency Model	T1019	UD				15 minutes = 1 unit
CFC PCS Attendant Care Only - Service Responsibility Option Model	T1019	U1				15 minutes = 1 unit
CFC PCS Attendant Care Only - Consumer Directed Services Model	T1019	U3				15 minutes = 1 unit

Community First Choice - Attendant Care and Habilitation (CFC- HAB)

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
CFC Attendant care and habilitation - Agency Model	T1019	U9				15 minutes = 1 unit
CFC Attendant care and habilitation - Service Responsibility Option Model	T1019	U2				15 minutes = 1 unit
CFC Attendant care and habilitation - Consumer Directed Service Model	T1019	U4				15 minutes = 1 unit

Emergency Response

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Emergency Response Monthly	S5161	U3	U3			1 month = 1 unit
Emergency Response Installation and Testing	S5160					1 unit per service

Personal Care Services (PCS)

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Personal Care Services - Agency Model	T1019	U6				15 minutes = 1 unit
Personal Care Services - Service Responsibility Option	T1019	US				15 minutes = 1 unit
Personal Care Services - Consumer Directed Service Model	T1019	UC				15 minutes = 1 unit
Personal Care Services, BH Condition- Agency Model	T1019	UA	U6			15 minutes = 1 unit
Personal Care Services, BH Condition- Service Responsibility Option	T1019	UA	US			15 minutes = 1 unit
Personal Care Services, BH Condition - Consumer Directed Service Model	T1019	UA	UC			15 minutes = 1 unit

Nurse Delegation and Supervision

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
RN Assessment for delegation of PCS or CFC tasks	G0162					15 minutes = 1 unit
RN Training and ongoing supervision of delegated tasks	G0162	U1				15 minutes = 1 unit

Private Duty Nursing

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Private Duty Nursing, LVN	T1000	TE				15 minutes = 1 unit
Private Duty Nursing, Specialized LVN	T1000	TE	UA			15 minutes = 1 unit
Private Duty Nursing, RN	T1000	TD				15 minutes = 1 unit
Private Duty Nursing, Specialized RN	T1000	TD	UA			15 minutes = 1 unit
Private Duty Nursing, Independently Enrolled LVN	T1000	U3	TE			15 minutes = 1 unit
Private Duty Nursing, Independently Enrolled Specialized LVN	T1000	U3	UA	TE		15 minutes = 1 unit
Private Duty Nursing, Independently Enrolled RN	T1000	TD				15 minutes = 1 unit
Private Duty Nursing, Independently Enrolled Specialized RN	T1000	UA	TD			15 minutes = 1 unit

Billing and Claims Administration

Prescribed Pediatric Extended Care

Service Description	HCPC Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Prescribed Pediatric Extended Care , greater than 4 hrs	T1025					4.25 hours or more = 1 unit
Prescribed Pediatric Extended Care, up to 4 hours	T1026					1 hour= 1 unit
Non emergency transportation	T2002					1 day = 1 unit

Financial Management Services

Service Description	HCPC Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Financial Management Service Fee PCS	T2040	U8				Monthly Fee
Financial Management Service Fee, CFC, non MPCP	T2040	U5				Monthly Fee

Billing and Claims Administration

MDCP Services

Out-of-Home Respite (Non-facility)

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Respite Care, Camp Setting	T2027					15 minutes = 1 unit

In Home Respite

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
In home respite, Attendant, Agency Model	H2015	U1				15 minutes= 1 unit
In Home Respite, Attendant, Service Responsibility Option	H2015	U1	US			15 minutes= 1 unit
In Home Respite, Attendant, CDS Option	H2015	U1	UC			15 minutes= 1 unit
In Home Respite, Attendant with RN delegation, Agency Model	H2015	U1	UA			15 minutes= 1 unit
In home Respite, Attendant with Rn delegation, Service Responsibility Option	H2015	U1	UA	US		15 minutes= 1 unit
In Home Respite Attendant with RN delegation, CDS Option	H2015	U1	UA	UC		15 minutes= 1 unit
Value Add, In home respite	H2021	U1				15 minutes= 1 unit
In home Respite, LVN , Agency Model	H2015	U3				15 minutes= 1 unit
In Home Respite, LVN , Service Responsibility Option	H2015	U3	US			15 minutes= 1 unit
In Home Respite, LVN, CDS Option	H2015	U3	UC			15 minutes= 1 unit
In Home Respite, Specialized LVN, Agency Model	H2015	U3	UA			15 minutes= 1 unit
In Home Respite, Specialized LVN, Service Responsibility Option	H2015	U3	UA	US		15 minutes= 1 unit
In Home Respite, Specialized LVN, CDS Option	H2015	U3	UA	UC		15 minutes= 1 unit
Value Add, In home respite	H2021	U3				15 minutes= 1 unit
In Home Respite, RN , Agency Model	H2015	U5				15 minutes= 1 unit
In Home Respite, RN , Service Responsibility Option	H2015	U5	US			15 minutes= 1 unit
In Home Respite, RN, CDS Option	H2015	U5	UC			15 minutes= 1 unit
In Home Respite, Specialized RN, Agency Model	H2015	U5	UA			15 minutes= 1 unit
In Home Respite, Specialized RN, Service Responsibility Option	H2015	U5	UA	US		15 minutes= 1 unit
In Home Respite, Specialized RN, CDS Option	H2015	U5	UA	UC		15 minutes= 1 unit
Value Add, In home respite	H2021	U5				15 minutes= 1 unit

Flexible Family Support Services

Service Description	HCPCode	Mod 1	Mod 2	Mod 3	Mod 4	Units
Flexible Family Support, Attendant, Agency Model	H2015	99	U1			15 minutes= 1 unit
Flexible Family Support, Attendant, Service Responsibility Option	H2015	99	U1	US		15 minutes= 1 unit
Flexible Family Support, Attendant, CDS Option	H2015	99	U1	UC		15 minutes= 1 unit
Flexible Family Support, Attendant with RN delegation, Agency Model	H2015	99	U1	UA		15 minutes= 1 unit
Flexible Family Support, Attendant with Rn delegation, Service Responsibility Option	H2015	99	U1	UA	US	15 minutes= 1 unit
Flexible Family Support Attendant with RN delegation, CDS Option	H2015	99	U1	UA	UC	15 minutes= 1 unit
Flexible Family Support, LVN , Agency Model	H2015	99	U3			15 minutes= 1 unit
Flexible Family Support, LVN , Service Responsibility Option	H2015	99	U3	US		15 minutes= 1 unit
Flexible Family Support, LVN, CDS Option	H2015	99	U3	UC		15 minutes= 1 unit
Flexible Family Support, Specialized LVN, Agency Model	H2015	99	U3	UA		15 minutes= 1 unit
Flexible Family Support, Specialized LVN, Service Responsibility Option	H2015	99	U3	UA	US	15 minutes= 1 unit
Flexible Family Support, Specialized LVN, CDS Option	H2015	99	U3	UA	UC	15 minutes= 1 unit
Flexible Family Support, RN , Agency Model	H2015	99	U5			15 minutes= 1 unit
Flexible Family Support, RN , Service Responsibility Option	H2015	99	U5	US		15 minutes= 1 unit
Flexible Family Support, RN, CDS Option	H2015	99	U5	UC		15 minutes= 1 unit
Flexible Family Support, Specialized RN, Agency Model	H2015	99	U5	UA		15 minutes= 1 unit
Flexible Family Support, Specialized RN, Service Responsibility Option	H2015	99	U5	UA	US	15 minutes= 1 unit
Flexible Family Support, Specialized RN, CDS Option	H2015	99	U5	UA	UC	15 minutes= 1 unit

Billing and Claims Administration

Financial Management Services

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Financial Management Service Fee - MDCP	T2040	U3				Monthly Fee
Financial Management Service Fee - CFC and MDCP	T2040	U4				Monthly Fee

Adaptive Aids (Waiver)

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Adaptive Aid - NOS	T2028					1 unit per service
Adaptive Aid- Medical Equipment	T2029					1 unit per service
Adaptive Aid - Vehicle Modification	T2039					1 unit per service

Minor Home Modifications

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Minor Home Modifications - Lifetime Max 7500	S5165					1 unit per service
Value Add Minor Home Modifications Maintenance	S5165	UE				1 unit per service

Transition Assistance Services

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Transition Assistant Services	T2038					1 unit per service

Supported Employment

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Supported Employment, Agency Model	H2025					15 minutes= 1 unit
Supported Employment, Service Responsibility Option	H2025	US				15 minutes= 1 unit
Supported Employment, CDS Option	H2025	UC				15 minutes= 1 unit

Employment Assistance

Service Description	HCP Code	Mod 1	Mod 2	Mod 3	Mod 4	Units
Employment Assistance, Agency Model	H2023					15 minutes= 1 unit
Employment Assistance, Service Responsibility Option	H2023	US				15 minutes= 1 unit
Employment Assistance, CDS Option	H2023	UC				15 minutes= 1 unit

Billing and Claims Administration

Benefit Limitations

Texas Children's Health Plan does not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Texas Children's Health Plan STAR Kids member.

Texas Children's Health Plan adheres to the benefit limitations as outlined in the Texas Medicaid Provider Procedures Manual.

Balanced Billing

It is important for providers to understand that Medicaid is considered to be the payer of last resort, meaning that if the patient has other coverages, those plans should be billed prior to billing Medicaid.

There are no co-payments for STAR Kids members.

Change Healthcare, formerly Emdeon, ePayment Services

Texas Children's Health Plan contracts with Change Healthcare to deliver ePayment services. Providers should strongly consider using electronic funds transfer (EFT) or virtual credit card (VCC) payments.

Electronic Funds Transfer (EFT)

Existing EFT customers with Change Healthcare that would like to add Texas Children's Health Plan to their service, can call 866-506-2830 and select Option 1 to speak with an Enrollment Representative.

For new EFT customers:

Visit the ePayment website www.changehealthcare.com/epayment to sign up today.

Providers can:

- Learn more about the EFT service offering.
- Check out Change Healthcare's Payer List to see all available EFT-enabled payers.
- Obtain the EFT enrollment forms.
- Register for online EFT enrollment and account management access.

Virtual Credit Card (VCC)

Instead of receiving paper check payments with an explanation of payment (EOP), Texas Children's Health Plan offers virtual card payments. The virtual credit card payment includes all the information necessary to collect the payment using the provider's current Point of Sale (POS) terminal. The payment is similar to how provider offices manually key in patient payments today. Standard merchant fees apply. No enrollment is necessary. Since funds are deposited almost immediately from Texas Children's Health Plan into a provider's merchant account, the provider receives payment more quickly. If a provider does not accept credit cards and would like to learn more, call 888-234-8897 to speak with a Chase Paymentech representative.

Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR Kids member's home to provide a service will document their arrival time, and departure time using a telephonic or computer-based application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the Health Plan for targeted EVV services.

Billing and Claims Administration

Do providers have a choice of EVV vendors?

Providers have a choice between two HHSC-approved vendors:

DataLogic (Vesta) Software, Inc.

Sales & Training Email: info@vestaevv.com

Phone: (888) 880-2400

Tech Support Email: support@vesta.net

Website: www.vestaevv.com

MEDsys Software Solutions, LLC

Sales Email: info@medsyshcs.com | Phone: (877) 698-9392; Option 2

Support Phone: (877) 698-9392; Option 1

Website: www.medsyshcs.com

During the contracting and credentialing process with a Health Plan, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. Forms are located at www.TexasChildrensHealthPlan.org/For-Providers.

Provider EVV default process for non-selection

Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.

When can a provider change EVV vendors?

- A provider may change EVV vendors 120 calendar days after the submission request by completing the Medicaid EVV Provider System Selection form.
- A provider may change EVV vendors twice in the life of their contract with the Health Plan.

Can a provider elect not to use EVV?

EVV will be required to document delivery of the following STAR Kids services:

- Personal care services (PCS)
- Community First Choice attendant care and habilitation (PAS/HAB)
- MDCP In-Home Respite
- MDCP flexible family support services

Is EVV required for CDS employers?

EVV is not required for CDS employers.

If a CDS employer chooses to utilize EVV there are three options:

- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

Will Provider Training (including CDS Employers) be offered to providers?

Electronic Visit Verification (EVV) training is available through our provider relations department. For training, please contact provider relations via phone 832-828-1008, toll free 1-800-731-8527 or email HealthPlan@texaschildrens.org.

Billing and Claims Administration

EVV use of small alternative device (SAD) process and required SAD forms

The SAD process and required SAD forms is found at:

<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification/evv-forms-handbooks>

Where do I submit the SAD agreement/order form?

The form is submitted to the provider-selected EVV vendor.

a) DataLogic - email form to: tokens@vestaevv.com or send secure efax to 956-290-8728

b) MEDsys - email form to: tokens@medsyshcs.com or send secure fax to 888-521-0692

Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition.

EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The Provider must enter Member information, Provider information, and service schedules (scheduled or nonscheduled) into the EVV system for validation either through an automated system or a manual system.
- The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- 90% Adherence to Provider Compliance Plan
 - HHSC EVV Initiative Provider Compliance Plan—A set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
 - Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System.

Provider Agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.

- The HHSC Compliance Plan is located at:

http://www.dads.state.tx.us/evv/complianceplan/HHSC_EVV_Provider_Compliance_Plan.pdf

- The Texas Children's Health Plan Compliance Plan is located at www.TexasChildrensHealthPlan.org

- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify the appropriate Health Plan, or HHSC, within 48 hours of any ongoing issues with EVV vendors with EVV Systems.
- Any corrective action plan required by a Health Plan is required to be submitted by the Network Provider to the Health Plan within 10 calendar days of receipt of request.
- The Health Plan Provider Agencies may be subject to termination from the Health Plan network for failure to submit a requested corrective action plan in a timely manner.

Billing and Claims Administration

Questions and concerns about EVV may be directed to:

Inquiry	Contact Information
HHSC general questions and complaints regarding an EVV vendor	Electronic_Visit_Verification@hhsc.state.tx.us
Complaints regarding EVV with Texas Children's Health Plan	1-800-731-8527
	HealthPlan@texaschildrens.org
Data Logic (Vesta) Software, Inc.	Tech Support: support@vesta.net
	Sales: (888) 880-2400
	Sales & Training: info@vestaevv.com
MEDsys Software Solutions, LLC	Support: (877) 698-9392; Option 1
	Sales: (877) 698-9392; Option 2
	Sales Email: info@medsyshcs.com

There will be no cost for to the Provider for the access and use of the selected EVV vendor system.

Providers of Home Health Services Responsibilities

Provider Compliance Plan (excluding Consumer-Directed Services (CDS):

<https://www.dads.state.tx.us/evv/complianceplan/HHSCProviderCompliancePlan.pdf>

Non-CDS EVV providers must adhere to the Provider Compliance plan found at www.tchp.us/providers) or by contacting Texas Children's Health Plan at 832-828-1008 or 1-800-731-8527 for the most current version.

Use of Reason Codes

Reason codes are used in visit maintenance when making corrections to a visit. Reason codes explain the specific reason a change was made to the visit. In addition to the reason code, the provider can enter free text in the EVV system. Providers must associate the most appropriate reason code with each change made in visit maintenance and enter any required free text in the comment field.

Reason codes have been categorized as preferred or non-preferred. Any reason code with a number less than 900 is a preferred reason code. Any reason codes with a number greater than or equal to 900 is a non-preferred reason code.

Some reason codes include the requirement to verify that services were delivered. Other reason codes list specific information to be verified, such as the identity of the attendant providing the services. Provider agencies must follow program policies and procedures to verify the required service delivery information for each visit as part of the visit maintenance process.

For most up to date reason codes:

<https://hhs.texas.gov/sites/hhs/files//documents/doing-business-with-hhs/providers/long-term-care/evv/hhsc-reason-code.pdf>

Will claim payment be affected by the use of EVV?

- Providers must adhere to EVV guidelines in Provider compliance plan when submitting a claim.
- Claims must be submitted within 95 calendar days of the EVV visit.
- Texas Children's Health Plan will pay the claim and retrospectively match the claim file with the EVV Transaction file. If there is not a matching EVV transaction for the claim, a recoupment will be processed.

Complaints Process

Provider Complaints Process to Texas Children's Health Plan

In accordance with the Texas Medicaid Provider Procedures Manual, Texas Children's Health Plan has a process for providers to file complaints. A provider complaint includes any dissatisfaction with any aspect of Texas Children's Health Plan's operations, including plan administration, the appeal of an adverse determination, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. Providers may file a complaint or appeal with Texas Children's Health Plan. The following information will assist providers in filing.

How to Submit Provider Complaints On Line

Providers may submit complaints on line through the email link on the Texas Children's Health Plan provider portal <http://www.texaschildrenshealthplan.org/for-providers> or by using the Provider Concern email box at TCHPPProviderConcerns@TCHP.us.

How to Submit Complaints via Paper

Complaint Issues by Providers dissatisfied with any aspect of Texas Children's Health Plan's operations may file a written or verbal complaint with Texas Children's Health Plan at the following address:

**Texas Children's Health Plan
Provider and Care Coordination
PO Box 301011 WLS 8394
Houston, TX 77230-1011
832-828-1008**

Time Frames for Complaints and Appeals

Complaint process:

Texas Children's Health Plan will send a written acknowledgement of a complaint within 5 business days. Texas Children's Health Plan will investigate and issue a response to a provider complaint within 30 calendar days.

Complaints regarding claims:

All appeals of denied claims and requests for adjustments on paid claims must be received by Texas Children's Health Plan within 120 days from the last date of disposition; the date of the Explanation of Benefits on which that claim appears. Notification of receipt of the request for an appeal will be sent to the provider within 5 business days of receipt of the request. Provider appeals will be responded to within 30 calendar days.

Emergency situations and appeals:

If a provider appeal involves a presently occurring emergency, denial of a continued hospital stay, or life-threatening condition, Texas Children's Health Plan shall respond in accordance to the medical immediacy of the case but in no event, greater than 1 business day from the time Texas Children's Health Plan receives the appeal. Texas Children's Health Plan will provide an oral resolution decision within 1 business day of receipt of an expedited appeal and in writing within 3 business days.

Non-emergent appeals:

All provider appeals involving medical necessity issues will be made by a physician. If an appeal is denied, the provider has 30 working days to set forth in writing good cause for having a particular type of specialty provider review the case, and the denial shall be reviewed by a provider in the same or similar specialty as typically manages the member's situation. An acknowledgement letter will be sent within five working days of receiving request for specialty review. Specialty review will be completed within 15 working days of receipt of request. Claims lacking the information necessary for processing are listed on the Explanation of Benefits requesting the missing information. Providers must resubmit a completed/corrected claim to Texas Children's Health Plan within 120 days from the date of the Explanation of Benefits to be considered for payment.

Documentation

Retention of fax cover pages, emails to and from Texas Children's Health Plan and maintain log of telephone communication.

- Both the provider and TCHP will retain all documentation including fax cover sheets, emails, telephone log of communication related to the expression of dissatisfaction.



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