

Texas Children's Health Plan Provider Manual



STAR/Medicaid

Austin	Hardin	Matagorda	San Jacinto
Brazoria	Harris	Montgomery	Tyler
Chambers	Jasper	Newton	Walker
Fort Bend	Jefferson	Orange	Waller
Galveston	Liberty	Polk	Wharton

Children's Health Insurance Program (CHIP)

Austin	Hardin	Matagorda	San Jacinto
Brazoria	Harris	Montgomery	Tyler
Chambers	Jasper	Newton	Walker
Fort Bend	Jefferson	Orange	Waller
Galveston	Liberty	Polk	Wharton



**Texas Children's[®]
Health Plan**

The best decision a family can make.



TEXAS STAR
Your Health Plan ★ Your Choice



ND-0218-315

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I.

Quick Reference Phone List

Texas Children's Health Plan Phone Numbers

Member Services

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

STAR members: 832-828-1001 or 866-959-2555

CHIP members: 832-828-1002 or 866-959-6555

Telephone TouCHPoint: 832-828-1007

Fax: 832-825-8777

Utilization Management

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

Phone: 832-828-1004

Fax: 832-825-8760

Hours of operation: 8 a.m. to 6 p.m., Monday through Friday

Provider and Care Coordination

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

Phone: 832-828-1008

Toll-free: 1-800-731-8527

Fax: 832-825-8750

Provider Hotline

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

Phone: 832-828-1004

STAR Dental Services

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



Texas Children's Health Plan Nurse Help Line

Phone: 1-800-686-3831

Electronic Funds Transfer (EFT)

Change Healthcare: 1-866-506-2830

Pharmacy Hotline

Navitus: 1-877-908-6023

Behavioral Health Hotline and Referral Line (STAR)

1-800-731-8529

Behavioral Health Hotline and Referral Line (CHIP)

1-800-731-8528

Telephone Numbers for Other Organizations

Organization	Telephone number
Involve Vision	CHIP 1-844-520-3711 STAR 1-844-683-2305
Childhood Lead Poisoning Prevention/DSHS	1-512-458-7151
CHIP (application and enrollment assistance)	1-800-647-6558
Comprehensive Care Program/TMHP	1-800-925-9126
Division for Blind Services	713-948-7960 or 1-800-687-7036
Early Childhood Intervention (ECI) Referral Line	1-800-628-5115
Family Planning Program	1-512-458-7111 ext. 7796
HHSC Help Line (members)	1-800-252-8263
HHSC Vendor Drug Services (providers only)	1-800-435-4165
Local Tuberculosis Control Health Authority (LTCHA)	1-800-705-8868
Medical Transportation Services (Medicaid members)	1-877-633-8747
Public Health Region 5/6	713-767-3000
STAR Help Line	1-800-964-2777
FCL Dental (for ages 21 and up)	1-866-548-8123
STD Reporting	1-713-794-9181
Texas Medicaid and Healthcare Partnership (TMHP)	1-800-925-9126 or 1-888-863-3638
Texas Vaccines for Children Program	1-800-252-9152
Texas Health Steps Hotline	1-877-847-8377
To enroll as a Texas Health Steps provider, TMHP	1-800-925-9126
Women, Infant, Children (WIC) information number	1-800-942-3678

II.

Introduction

Texas Children's Health Plan Overview

Texas Children's Health Plan was founded in 1996 as the first pediatric health plan in the nation. Today, Texas Children's Health Plan serves children and pregnant women in STAR, CHIP and STAR Kids programs in the Harris and Jefferson service areas as well as CHIP and STAR Kids in the Northeast Rural Service Area.

Texas Children's Health Plan is part of Texas Children's Hospital with operations located in Houston and provider relations representatives located throughout the Harris, Jefferson and Northeast Service Areas. Texas Children's Health Plan strives to improve both the provider experience and the health of the communities we serve.

Products

Texas Children's Health Plan functions as an administrator for the Children's Health Insurance Program (CHIP), CHIP Perinatal, STAR/Medicaid, and STAR Kids managed care programs through a contract with the state Medicaid administrator, Texas Health and Human Services Commission (HHSC).

Children's Health Insurance Program



Texas Children's Health Plan has worked with CHIP since the CHIP program began in 2000. The program is designed for families who earn too much money to qualify for Medicaid yet cannot afford to buy private insurance for their children. CHIP provides eligible children (up to age 19) with treatment for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and more. Texas Children's Health Plan is one of the MCO choices for a CHIP eligible child in the Harris, Jefferson, and Northeast Service Areas. Effective March 1, 2012, Texas Children's Health Plan also participates in CHIP Perinatal, designed for pregnant women who are under 200% of Federal Poverty Level and do not qualify for Medicaid.

STAR/Medicaid Managed Care



Texas Children's Health Plan is contracted with Health and Human Services Commission as an MCO providing health care services to STAR members in the Harris and Jefferson Service Areas. The STAR program provides for a full range of Medicaid health services to newborns, pregnant women, children, and adults.

STAR Kids



Since November 2016 Texas Children's Health Plan has provided services through STAR Kids, the Medicaid managed care program serving children with medical complexities. Texas Children's Health Plan serves children in the STAR Kids program in the Harris and Jefferson Service Areas as well as the Northeast Medicaid Rural Service Area.

Using the Provider Manual

Texas Children's Health Plan welcomes you as a participating provider in our network. This manual is designed to provide you with information needed when treating a Texas Children's Health Plan member. It contains information regarding administrative procedures, medical management procedures and programs, and quality improvement programs. This manual is reviewed periodically and may be changed as needed. The most recent information for providers is also available on our website at www.TexasChildrensHealthPlan.org.

New services may be added at any time. For STAR, as an additional program reference, providers may use the Texas Medicaid Provider Procedures Manual online at www.tmhp.com. This website provides the latest information and general guidance for Texas Medicaid providers and contains information about Texas Medicaid benefits, policies, and procedures. It also contains the most recent updates in the Medicaid Provider Bulletins section, released every other month.

NOTE: Providers often confuse Texas Children's Health Plan (TCHP) with TMHP (administrator for Medicaid fee-for-service program) because they sound alike, but each is a distinct provider of Medicaid services, so please contact Texas Children's Health Plan for questions about eligibility and services for Texas Children's Health Plan members.

If you have any questions or need additional information about Texas Children's Health Plan, please contact Provider and Care Coordination by calling 832-828-1008 or toll-free 1-800-731-8527.

Health Insurance Portability and Accountability Act of 1996

Electronic code sets and standard transactions

Federal regulations effective October 16, 2003, require covered entities (health plans, physicians, hospitals, labs, pharmacies, and other health care providers) to comply with Health Insurance Portability and Accountability Act (HIPAA) approved transactions and code sets for dates of service on or after October 16, 2003. Providers must submit electronic claims in accordance with ASCX12 Version 4010 format. Texas Children's Health Plan currently receives electronic transactions through 3 clearinghouses—WebMD, Availity, and Legacy. Texas Children's Health Plan does not accept electronic UB-92 claims for STAR through Availity. Providers should contact their clearinghouses for questions regarding electronic claims submission.

Clearinghouse	Texas Children's Health Plan CHIP Payer ID	Texas Children's Health Plan STAR Payer ID
Change Healthcare (Formerly Emdeon)	76048	75228
Availity	76048	TXCSM

Contact Provider and Care Coordination at 832-828-1008 if you need assistance forwarding your claims to Texas Children's Health Plan through your clearinghouse.



Standards for Medical Records

Accessibility and Availability of Medical Records

Texas Children's Health Plan includes provisions in contracts with subcontractors for appropriate access to the medical records of its members for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, state agencies, or any agents thereof.

Texas Children's Health Plan directs that appropriate medical records for the member will be available to health care providers at each encounter.

Record Keeping

Medical records may be on paper or electronic. Texas Children's Health Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review.

- Medical record standards—Texas Children's Health Plan sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards will, at a minimum, include requirements for:
 - Patient identification information—Each page or electronic file in the record contains the patient's name or patient ID number.
 - Personal/biographical data—Includes age, sex, address, employer, home and work telephone numbers, and marital status.
 - All entries are dated and author identified.
 - The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
 - Allergies—Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies—NKA) is noted in an easily recognizable location.
 - Past medical history (for patients seen 3 or more times)—Easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
 - Immunizations—For pediatric records there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
 - Diagnostic information.
 - Medication information (includes medication information/instruction to patient).
 - Identification of current problems—Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical record.
 - Patient is provided basic teaching/instructions regarding physical and/or behavioral health condition.
 - Smoking/alcohol/substance abuse—Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.
 - Consultations, referrals, and specialist reports—Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
 - All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
 - Hospital discharge summaries—Discharge summaries are included as part of the medical record for:
 - All hospital admissions that occur while the patient is enrolled with Texas Children's Health Plan.
 - Prior admissions as necessary.
 - Prior admissions as necessary pertain to admissions that may have occurred prior to patient being enrolled with Texas Children's Health Plan, and are pertinent to the patient's current medical condition.
 - Advance directives—For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
 - A written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.
 - Written procedures for release of information and obtaining consent for treatment.

- Documentation of evidence and results of medical, preventive, and behavioral health screening.
- Documentation of all treatment provided and results of such treatment.
- Documentation of the team members involved in the multidisciplinary team of a member needing specialty care.
- Documentation in both the physical and behavioral health records of integration of clinical care. Documentation to include:
 - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated.
 - Screening and referral by behavioral health providers to primary care providers when appropriate.
 - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
 - At least quarterly (or more often if clinically indicated), a summary of status/progress from the behavioral health provider to the primary care provider.
 - A written release of information which will permit specific information sharing between providers.
 - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Patient Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and physical examination—Appropriate subjective and objective information is obtained for the presenting complaints.
- For members receiving behavioral health treatment, documentation to include “at risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
- Admission or initial assessment—This includes current support systems or lack of support systems.
- For members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- Plan of treatment—This includes activities/therapies and goals to be carried out.
- Diagnostic tests.
- Therapies and other prescribed regimens—For members who receive behavioral health treatment, documentation will include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.
- Follow-up—Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals and results.
- All other aspects of patient care, including ancillary services.

Record Review Process

Texas Children’s Health Plan has a system (record review process) to assess the content of medical records for legibility, organization, completion, and conformance to its standards.

Role of a Primary Care Provider (Medical Home)

The role of the primary care provider is to provide a medical home through which members receive services that:

- Maintain their health status.
- Provide anticipatory guidance at all ages.
- Help with addressing the clinical manifestations associated with chronic diseases.

One of the principle objectives of Texas Children's Health Plan is to enhance member access to health care by providing a medical home for enrolled members. A primary care provider who has accepted responsibility for providing accessible, continuous, comprehensive, and coordinated care will be considered the medical home for the member.

Primary care providers may include the following specialties:

- Pediatricians
- Family practitioners
- Internists
- General practitioners
- Federally Qualified Health Center (FQHC)
- Rural health clinics
- Pediatric and Family Advanced Nurse Practitioners (FANP)
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Obstetricians/gynecologists electing to be a primary care provider
- Certified Nurse Midwives (CNM) electing to be a primary care provider

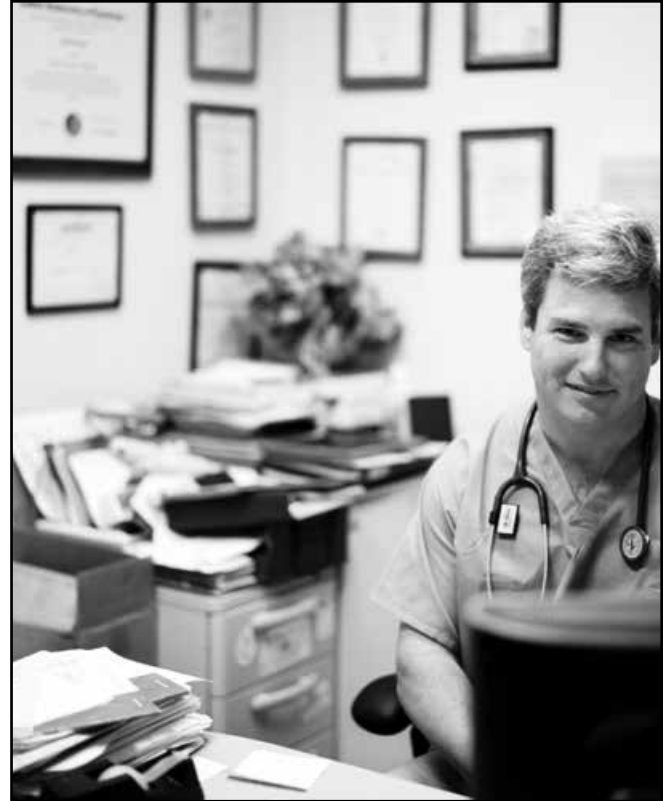
For members with special medical needs, physicians practicing in specialties other than traditional primary care specialties can be denoted as the medical home. Members with special medical needs are identified in the medical management system and, as such, have care plans developed by Care Management staff in collaboration with the physician acting as the medical home for these members.

In order to provide quality medical care for Texas Children's Health Plan members, a Texas Children's Health Plan contracted provider who is designated as the primary care provider medical home for the Texas Children's Health Plan member has certain responsibilities.

Role of CHIP Perinatal Provider (for CHIP Perinatal only)

The role of the CHIP Perinatal provider is to provide pregnancy services. Since benefits are limited to prenatal care only, there will be a pregnancy care provider listed. Perinatal care providers may include:

- Family practitioners
- Obstetricians/Gynecologists
- Internists
- Advanced Nurse Practitioners
- Certified Nurse Midwives
- Clinics (FQHC, RHC)



Primary Care Provider Responsibilities

- Maintaining 24-hours-per-day, 7-days-per-week accessibility to medical care, including advising members who require urgent or emergent care. Such access includes regular office hours on weekdays and availability of physician or a covering physician by telephone outside of regular hours, including weekends and holidays.
- Coordinating the provision of covered services to Texas Children's Health Plan members by:
 - Providing or arranging for medically necessary services for eligible Texas Children's Health Plan members that conform to accepted community standards of practice.
 - Educating patients and their families regarding their medical needs.
 - Initiating referrals for specific covered services to other in-network health care professionals and facilities when services required are not available from the primary care provider.
 - Monitoring the progress of care and coordinating utilization of services to facilitate the return to the primary care provider as soon as medically appropriate.
- Cooperation with Texas Children's Health Plan's Care Management Department by:
 - Providing clinical information when necessary.
 - Participating in care plan development for Texas Children's Health Plan members with chronic diseases.
 - Providing for member continuity of care.
 - Reporting pregnancies to the Texas Children's Health Plan Maternal Child Program after the first prenatal visit.
- Cooperation with Texas Children's Health Plan's Utilization Management Program.
- Completing and submitting claim forms in accordance with the provider agreement and provider manual.
- Verifying eligibility and/or authorizations for service of each member at each time of service.
- Complying with the Texas Children's Health Plan quality management programs, which include periodic office site reviews, medical record reviews, and mutually agreed-upon corrective action plans if applicable.
- Advising members of their right to sign an advance directive.

Preventive Health Services

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

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

Additional Primary Care Provider Responsibilities

- Maintain confidentiality of personal health information (PHI) for Texas Children's Health Plan members.
- Maintain 24-hours-a-day, 7-days-a-week access to medical care, including advising members who require urgent or emergent care.
- Provide or arrange for routine medically necessary care within 2 weeks of a request and for urgent care within 24 hours of the request.
- Maintain an open panel for membership unless notification to close panel is given to the Health Plan with 30 days notice.

- Maintain staff membership and admission privileges in good standing with at least 1 hospital contracted with Texas Children's Health Plan, unless otherwise approved.
- Be aware of culturally sensitive issues with members.
- Ensure written materials given to members are on a fourth- to sixth-grade reading level.
- Provide care to eligible children who are receiving service from or have been placed in the conservatorship of Texas Department of Protective and Regulatory Service (DFPS).
- Agree not to refer or direct patients to hospital emergency rooms for non-emergent medical services at any time.
- Assist in educating and instructing Texas Children's Health Plan members about the proper utilization of provider office visits in lieu of the emergency room.
- Maintain both general liability and professional liability insurance of a type and in the amounts acceptable to HHSC as specified in the HHSC Uniform Managed Care Contract.
- Meet all of the Texas Children's Health Plan credentialing and re-credentialing requirements.
- Ensure release of confidential information as described in the Texas Medicaid Provider Procedures Manual.
- Complete and submit claim forms using the assigned provider number and prior authorization number.
- Maintain all medical records relating to members for a period of at least 5 years from the initial date of service.
- Comply with federal regulations that protect against discrimination and the federal Americans with Disabilities Act.
- Maintain any and all licenses in the State of Texas as required by the laws governing his/her profession or business.
- Notify of any policy or procedure that creates a barrier to care.

Please note that Texas Children's Health Plan does not require authorization for a primary care provider to refer to any in-network specialist. Providers may confirm a specialist's network status by calling Provider and Care Coordination at 832-828-1008 or visiting www.TexasChildrensHealthPlan.org for provider listings.

Specialist Functioning as Primary Care Provider

Specialist physicians may be designated to function as primary care provider for a member with disabilities, special health care needs, or unstable chronic conditions who requires a level of service coordination and technology that is beyond the scope and role of a general practitioner. Texas Children's Health Plan's designation of a specialist functioning as primary care provider requires prior authorization by completing the Primary Care by Specialist Request Form located on the Texas Children's Health Plan website at www.TexasChildrensHealthPlan.org and click on the *Downloadable Forms* link under the Providers section. The form can also be found in the *Helpful Forms* section of this manual.

The application must:

- Include information specified by the health maintenance organization and certification of the medical need.
- Be signed by the member and the non-primary care physician specialist interested in serving as the member's primary care physician.

The non-primary care physician specialist requesting to function as the member's primary care physician must certify and adhere to the following:

- Have demonstrated expertise in treating a particular disease and/or condition.
- Agree to abide by Texas Children's Health Plan policies and procedures.
- Agree to accept the responsibility to coordinate all of the member's health-care needs including preventive care examinations, immunizations, and treatment of minor intercurrent illness.
- Agree to provide 24-hour, 7-day-a-week on-call coverage through a system staffed by other similarly qualified physicians.

Upon receipt of the completed form:

- The Medical Director will evaluate the non-primary care physician specialist's credentials to ensure he or she meets the primary care physician criteria.
- The Medical Director consults and communicates directly with both the original primary care physician and the non-primary care physician specialist functioning as the primary care provider to explore and suggest other alternatives.

- The Manager of Contracting will evaluate the non-primary care physician specialist's contractual obligations to ensure consistency with the primary care physician's contractual obligations.
- The Medical Director will make a decision within 15 business days of receipt of the completed form unless additional records are needed. The Medical Director will then make a decision within 10 business days of receipt of the supplemental records.

Approval of request:

Appropriate written notification will be sent to the member, the non-primary care physician specialist, and the former primary care physician, including the effective date of the change.

- Effective date of the change which will be processed according to Texas Children's Health Plan policy for changing primary care physicians.
- Effective date may not be applied retroactively.
- Compensation owed to the original primary care physician for services provided before the date of the new designation will not be reduced.
- The non-primary care physician specialist functioning as primary care physician continues as long as the patient's needs warrant this level of expertise and meet Texas Children's Health Plan's policy.

Denial of the request:

Appropriate written notification will be sent to the member, the non-primary care physician specialist, and the former primary care physician, which includes:

- Reason for denial.
- Necessary appeal information relative to the adverse determination in accordance with the Texas Children's Health Plan Provider Manual.
- Members may appeal through the Texas Children's Health Plan member complaint and appeal process.
- Providers may appeal on behalf of a member in accordance with the Complaints and Medical Appeals section of the Provider Manual.

Texas Children's Health Plan is required to report to Health and Human Services Commission on a quarterly basis the number of non-primary care physician specialists functioning as primary care physicians under the STAR program including, but not limited to, the number and nature of complaints about these specialists.

Role of a Specialty Care Provider

Specialist providers are responsible for treating members who have been referred to them by participating primary care providers. Specialists must:

- Provide specialty services upon referral from the primary care provider.
- Work closely with primary care provider to enhance continuity in health services to members.
- Advise the primary care provider in writing regarding findings in a consultation, recommendations or an ongoing treatment program.
- Notify primary care provider if another specialist is needed.
- Notify the primary care provider and Texas Children's Health Plan when a specialist wishes to admit a member to a hospital and provide information necessary to authorize the admission. **Texas Children's Health Plan does not require pre-authorization for in-network specialists to treat members.**

Member eligibility may be confirmed by calling Member Services at 832-828-1004 or online through Provider TouCHPoint at www.TexasChildrensHealthPlan.org/Providers.

Network Limitations

Texas Children's Health Plan has an open network. Providers can refer to the Texas Children's Health Plan website or the current provider directory for a list of primary care providers, specialists, OB/GYN physicians, behavioral health providers, and facilities.



Role of Pharmacy

Texas Children's Health Plan makes payment for prescriptions of covered outpatient drugs only to pharmacy providers contracted with Navitus. Medicaid members may receive medically necessary prescriptions from the Medicaid enrolled pharmacy of their choice. The only drugs eligible for Navitus reimbursement are listed in the current Texas Listing of National Drug Codes. When HHSC-approved drugs are furnished by prescription, payment is made to pharmacies contracted with Navitus.

Texas Children's Health Plan is responsible for assisting members with medication management through their primary care provider and/or specialists. Texas Health Steps-eligible members may have unlimited, but medically necessary, prescriptions under the program.

Questions regarding Navitus should be directed to Navitus at 1-866-333-2757, Monday through Friday, 8:30 a.m. to 5 p.m. or by visiting the Navitus website at <http://www.navitus.com/texas-medicaid-star-chip/formulary.aspx>.

Role of Main Dental Home

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

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

III.

Behavioral Health

Definition of Behavioral Health

Behavioral health services are covered services for the treatment of mental and emotional disorders as well as chemical dependency disorders.

An emergency behavioral health condition is any condition, without regard to the nature or cause of the condition, which requires immediate intervention or medical attention. Without this emergency behavioral health treatment or intervention, members might present an immediate danger to themselves or others, or members may be incapable of controlling, knowing, or understanding the consequences of their actions.

Medically necessary behavioral health services are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder.
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
- The most appropriate level or supply of service that can safely be provided.
- Not omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

The mental health priority populations are those individuals served by Texas Mental Health Mental Retardation (TXMHMR). This group is defined as children and adolescents, under the age of 18, who exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.

Also included in this group are adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

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.

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.

Member Access to Benefits of MHR Services and TCM

For Members with an Intellectual or Developmental conditions the Member must be eligible for Medicaid and meet an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID) to qualify for Community First Choice services. The Local IDD Authority (LIDDA) conducts the eligibility assessment to determine eligibility and sends that assessment to HHSC's Administrative Services Contractor for a determination. The LIDDA completes the Determination of Intellectual Disability (DID) and Intellectual Disability Related Condition (ID/RC) assessments.

Providers of MHR services and TCM services must use and be trained and certified to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs Strength Assessment (ANSA) for members 19 and 20. Providers must use the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

Attestation from Provider entity to Health Plan that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG. HHSC has established qualifications and supervisory protocols for providers of MHR and TCM Services.

Provider Requirements

- Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs and Strength Assessment (ANSA) for members 19 and 20.
- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).
- Attestation from Provider entity to Texas Children's Health Plan that organization has the ability to provide, either directly or through subcontract, the Members with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC-established qualification and supervisory protocols.

Behavioral Health Services

Member Access to Behavioral Health 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 members may call 1-800-731-8529 and CHIP members may call 1-800-731-8528. (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



Major Depression Indicators

- Diagnosis is supported by a minimum of 5 symptoms documented in the medical record per DSM.
- Patient is treated in appropriate setting based on level of care guidelines.
- During initial assessment, the following are assessed:
 - Suicide risk
 - History and physical, and/or the initial assessment documents for co-existing medical problems (i.e., dementia, epilepsy, HTN, cardiac disease) and substance abuse history
 - Current medications including over-the-counter and prescribed psycho-tropics. A Texas Children's Health Plan Clinical Case Manager is also available to assist in identifying other community services.
- Medical record shows improvement with medication and psychotherapy within 6 to 8 weeks. If not, medical record shows that medication was changed or other psychotherapy added.
- Improvement in symptoms is documented during the hospital stay. If not, outpatient sessions or alternatives are considered.
- If diagnosed with psychotic depression, a combination of psychotherapy, anti-depressant, and anti-psychotic medication is utilized or there is documentation as to why not.
- Electroconvulsive therapy (ECT) is considered if no response to 2 full medication trials (no less than 16 weeks).
- Evidence that patient has follow up with a therapist or physician within 7 days of discharge from inpatient facility/program.

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.

Substance Abuse Indicators—Opioid Abuse

- Diagnosis is supported by symptoms documented in the medical record per DSM.
- Patient is treated in appropriate setting based on level of care guidelines.
- During initial assessment the following is assessed:
 - Suicide risk
 - Severity of withdrawal symptoms (past and present)
 - Most recent amount of substance used
 - Time lapsed since last use
 - Frequency and duration of use
 - Routes of administration
 - How patient feels drugs/alcohol affects him/her (including alcohol and any other drugs)
 - Complete psychiatric history
 - Substance use history
 - Treatment history
 - Family history
 - Social issues
 - Vocational issues
 - Relationship issues
 - Financial status
 - Legal status
 - Psychiatric or medical illness as etiology of symptoms
 - Medical evaluation
 - Motivation for treatment (Why now?)
 - Current prescription and OTC medications
- The patient is referred (or not) for psychiatric evaluation when symptoms, history, and/or testing indicates the need.
- Improvement in symptoms is noted during subsequent sessions or days in hospital or documentation for reasons for lack of improvement and alternatives considered.
- If diagnosed with withdrawal syndrome, appropriate application of detoxification guidelines is documented or documentation of reasons not using guidelines.
- If there is a lack of progress, other levels of care, modes of treatment, and/or other professionals are considered for consultation.
- Written plan for relapse prevention including high-risk periods.
- Documentation of use of long-term (beyond 7 day detox) medications and response (if applicable, i.e. Methadone).
- Documentation of continued evaluation for suicide.
- Referral to appropriate aftercare for long-term monitoring.

7- and 30-Day Mental Health Follow up Requirement

Texas Children's Health Plan members admitted to an acute psychiatric facility are required to follow up with an in-network Behavioral Health Provider within 7 days of discharge and again within 30 days of discharge. The appointment must be with an in-network psychiatrist, psychologist, or therapist. Missed appointments must be rescheduled within 24 hours.

Due to availability, it is better to schedule an appointment with a therapist for the 7-day follow up and see the therapist continuously until the psychiatric 30-day follow up appointment is met. This ensures the members are seen post discharge when they may be most vulnerable to relapse. The members can continue to work through any issues in therapy on an outpatient basis and see the psychiatrist to monitor their medications and adjust if necessary.

Inpatient psychiatric services must be provided to Texas Children's Health Plan members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities. Texas Children's Health Plan cannot deny, reduce, or controvert the medical necessity of any of these court-ordered inpatient psychiatric services, nor can the member appeal these court ordered commitments through Texas Children's Health Plan's complaint or appeals process.

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.

Primary Care Provider Referral

A Texas Children's Health Plan primary care provider can call Texas Children's Health Plan at 832-828-1004 to refer patients for behavioral health services or a Texas Children's Health Plan member may self refer, without referral from primary care provider, to any in-network behavioral health care provider. Texas Children's Health Plan provides information to members regarding how and where to obtain behavioral health services.

Substance Use Disorder Treatment Benefits

A Medicaid member can self-refer or be referred to receive an assessment. No referral from a primary care provider is needed and no prior authorization is needed for an assessment. Client assessments will be provided by a chemical dependency treatment facility licensed by Department of State Health Services (DSHS) that is in Texas Children's Health Plan's provider network. Following the initial assessment, the facility will seek prior authorization, if required, to begin services. To locate a network provider, you can:

- Call the Texas Children's Health Plan Behavioral Health Hotline. STAR members may call 1-800-731-8529 and CHIP members may call 1-800-731-8528.
- Contact a provider and ask if that provider participates in Texas Children's Health Plan's network.
- Look up a provider in the Texas Children's Health Plan provider directory. (Provided upon enrollment)
- Look up a provider on Texas Children's Health Plan's website at www.TexasChildrensHealthPlan.org.

The Medicaid Substance Use Disorder treatment services include:

- Outpatient services (effective September 1, 2010)
 - Clinical assessment.
 - Ambulatory detoxification.
 - Outpatient individual and group chemical dependency counseling.
 - Medication assisted treatment.

Coordination Between Behavioral Health and Physical Health Services

Consent for Disclosure of Information

Information concerning the diagnosis, evaluation, or treatment of a Texas Children's Health Plan member by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental, or emotional disorder, or drug abuse, is normally confidential information which the provider may disclose only to authorized persons. Family planning information is particularly sensitive and confidentiality must be assured for all clients, especially minors. Client information may only be released after the client provides a written release of information.

Coordination with Local Mental Health Authority

The Local Mental Health Authority (LMHA) functions to perform assessments to determine eligibility for rehabilitative and targeted MHMR case management services. Providers of outpatient behavioral health services who believe their Texas Children's Health Plan member qualifies for targeted case management or rehabilitation services through the LMHA may refer to the LMHA office nearest to the member. The member will be assessed to determine if he/she meets criteria for Severe and Persistent Mental Illness (SPMI) or Severe Emotional Disturbance (SED).

Texas Children's Health Plan Behavioral Health Case Management (832-828-1270) will facilitate discussion and/or staffing regarding the overall needs of these members. Providers can also contact the following local mental health authority directly.

Mental Health Authority/Mental Retardation Authority in Fort Bend County and Waller County

Name of center: Texana MHMR Center

Crisis phone: 1-800-633-5686

Main phone: 281-342-9387

Website: www.texanacenter.com

Mental Health Authority/Mental Retardation Authority in Harris County

Name of center: MHMRA of Harris County

Crisis phone: 1-866-970-4770

Main phone: 713-970-7000

Website: www.mhmraharris.org

Mental Health Authority/Mental Retardation Authority in Galveston County and Brazoria County

Name of center: The Gulf Coast Center

Crisis phone: 1-866-729-3848

Main phone: 281-488-2839

Website: www.gcmhmr.com

Mental Health Authority/Mental Retardation Authority in Montgomery, Walker, and Liberty County

Name of center: Tri-County MHMR Services

Crisis phone: 1-800-659-6994

Main phone: 936-756-8331

Website: www.tcmhmrs.org

Assessment Instruments for Behavioral Health

Texas Children's Health Plan providers must use the DSM multi-axial classification and report axes I, II, III, IV, and V for the assessment of behavioral health/mental health diagnoses. This information as well as assessment/outcome information is to be documented in the member's medical record. Behavioral health/mental health assessment tools include the:

- PSC-Y Pediatric Symptom Checklist for Youth (Assessment of depression, anxiety, ADHD, conduct disorder, oppositional defiant disorder and suicidality. For ages 11–18. Available at Teenscreen website below.
- PHQ-9 Patient Health Questionnaire (Depression and Suicidality) available at Teenscreen website below.
- CRAFFT for adolescents and adults (Substance Abuse Questionnaire): Available at Teenscreen website below.
- For the PSC-Y, PHQ-9 and CRAFFT assessments in English and in Spanish please visit <http://www.teenscreen.org/programs/primary-care/beginscreening/>.
- Brief Psychiatric Rating Scale (BPRS)—(Ages 17 and older) can be downloaded from <http://imaging.ubmmedica.com/all/editorial/psychiatrictimes/pdfs/2012/clinical-scales-bprs-form.pdf>.
- Global Assessment Functioning Scale (GAF)—Scores for patients of all ages (scores are to be documented upon admission and upon discharge or every 3 months during treatment).

Physical Health Lab/Ancillary Tests

Behavioral health providers are required to refer members with physical health problems to their primary care provider for treatment. Members must also obtain lab and ancillary tests for behavioral health conditions at participating provider locations.

Behavioral Health Focus Studies and Utilization Management Reporting

Texas Children's Health Plan will gather information from the following sources for UM/QI reports:

- Modified HEDIS measures performed on 100 percent of submitted claims/encounters. The data is obtained through medical records data, provider, and member surveys.
- Randomly selected member records.
- Encounter/claims data as submitted on HCFA 1500 or UB-92 format.

Provider profiling will be completed and will be made available to the provider. Texas Children's Health Plan is contractually required to inform and include all providers in Health Plan quality reporting and activities including provider and member surveys.

IV.

Quality Management

Quality Improvement Program Overview

Texas Children's Health Plan, through its Quality Assessment and Performance Improvement (QAPI) Program, strives to see that members, regardless of their source of eligibility, are provided with high-quality health care and services. Through the continuous, objective, and systematic process of measuring and analyzing key clinical and service indicators against regional and national benchmarks, taking action and re-measuring, the Health Plan and its participating network of providers pursue opportunities for improvement in clinical health care and non-clinical service outcomes.

The scope of the QAPI program provides for the review of the entire range of care provided by ensuring that all demographic groups, care settings, and services are included.

Care settings monitored include:

- Care given in institutional settings.
- Care given in non-institutional settings.
- Care given in individual physician and other providers' offices.

Texas Children's Health Plan monitors clinical and service measures including, but not limited to, quality of care, preventive care, acute and chronic care, accessibility and availability of care, efficient utilization of resources, and member/provider satisfaction.

Clinical Practice Guidelines

Texas Children's Health Plan, with the guidance of its Medical Advisory Committee, develops the following standards and practice guidelines:

- Preventive care, acute care, and chronic care standards utilizing national standards as appropriate and as designated by the Texas Health and Human Services Commission.
- Prenatal care standards based on the minimum standards of the American College of Obstetricians and Gynecologists (ACOG).
- Immunization based on the Advisory Committee on Immunization Practices.
- The Texas Health Steps periodicity schedule for STAR members.
- The American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care Guidelines for CHIP members.
- Clinical practice guidelines are reviewed every 2 years and updated as needed. Texas Children's Health Plan disseminates the guidelines to the provider network and upon request to members.
- American Academy of Child and Adolescent Psychiatry.

Quality Improvement Projects

Performance Improvement Projects (PIPs) follow the general continuous quality improvement process. PIPs may be identified through the established clinical care and non-clinical service performance indicators (measurements) that Texas Children's Health Plan utilizes to monitor quality of care and service or through Health Plan staff, provider, or member experiences that identify problems which represent a pattern or trend with an opportunity to improve care or service.

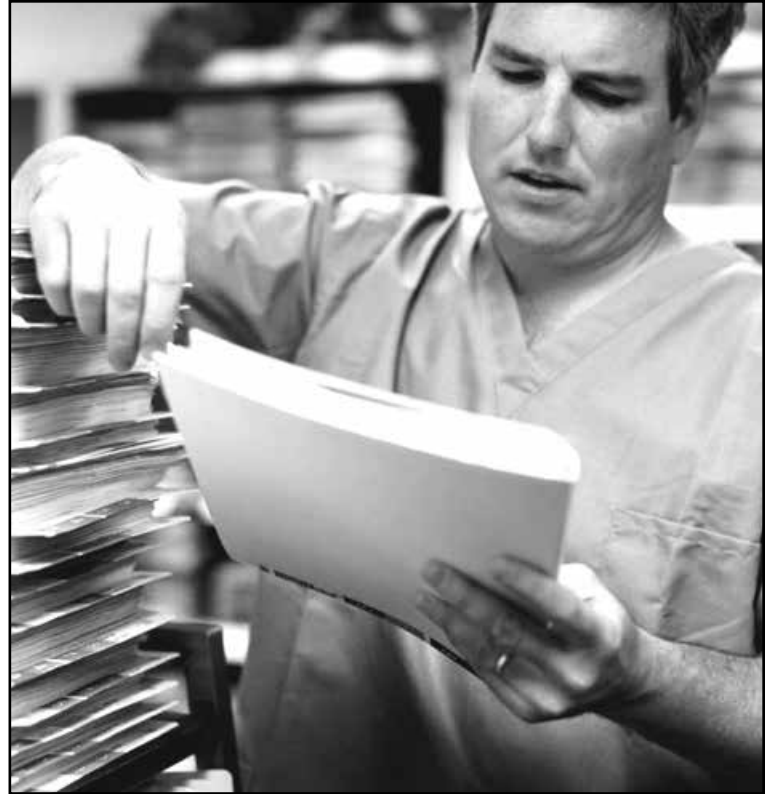
PIPs are reported on a format that demonstrates the relevance of the activity, validity of the study design, quantitative and qualitative analysis of results, barrier analysis and determination of opportunity for improvement, and strength of interventions.

PIP interventions and results are communicated to providers through newsletters and faxes as appropriate. Data and information specific to a provider or geographic area may be communicated during scheduled office visits by the Quality Improvement nurse or the Provider Relations Manager.

Examples of Texas Children's Health Plan's Performance Improvement Projects include the following:

- Medical Home QI Project
 - Objective: Improve Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) documentation, accuracy of claims, and increase the number of Texas Children's Health Plan members receiving EPSDT through educational outreach to primary care providers.
- Emergency Center Diversion
 - Objective: Decrease inappropriate emergency center utilization through member and primary care provider educational outreach targeting specific geographic areas.
 - Objective: To decrease the percentage of members receiving care later in the infectious process in emergency center or inpatient setting through educational outreach to members in targeted geographic areas.
- Skin and Soft Tissue Infections
 - Objective: Decrease inappropriate emergency center utilization through member and primary care provider educational outreach targeting specific geographic areas.
 - Objective: To decrease the percentage of members receiving care later in the infectious process in emergency center or inpatient setting through educational outreach to members in targeted geographic areas.

New PIPs will be designed and communicated as developed.



V.

Billing and Claims

Claims Submission

Claims must be submitted on a standard HCFA 1500 Form or UB-92/UB-04 to the address designated on the member's card. Emergency service claims are required to follow all claims billing procedures.

Required Information for HCFA 1500 Claims

- Member name.
- Member date of birth.
- Member's CHIP or Medicaid ID number.
- Member's relationship to insured.
- Information on any other coverage applicable to the member.
- If there is any other insurance on member, provide policy and/or group number.
- Insurance plan name.
- Enter any amount paid by an insurance company or other sources known at the time of submission of claim.
- Claims for treatment of an injury must include injury date.
- Referring physician's name, if applicable.
- ICD-9/10 diagnosis codes.
- Provider's NPI number.
- STAR claims must include TPI number.
- Date of service(s).
- Place of service.
- CPT-4 or HCPCS procedure codes with modifiers where appropriate.
- Diagnosis or nature of illness or injury—must be sequential.
- Tax ID number of the physician for the service.
- Total charge—should be on last page of claim only.
- Signature of treating physician for the services.
- Name and address of facility where service(s) rendered.
- Billing name and address of physician/provider.
- Days or units—for anesthesia claims, whole numbers need to reflect total minutes, not units.

When submitting a claim, please follow the guidelines below:

- A separate claim must be completed for each member and each provider.
- Please allow 30 days for claim processing prior to submitting a duplicate claim.

When submitting a replacement or appeal claim, please follow the guidelines below:

- Replacement claim submission: Refiling an entirely new claim to replace the previous claim. Providers can submit replacement claims either electronically or by paper.
 - Paper submission: Provider should indicate "corrected claim" and list all claim lines including previously paid lines from previous claim.
 - Electronic submission: "7" should be entered in the loop 2300, segment CLM05-3. This indicates replacement claim.

- Adjustment/appeal claim submission: Reconsideration of previously processed (denied or paid) claim for reconsideration.
 - Providers can resubmit the affected claim or claim lines as a new claim both electronically or by paper.
 - Claim appeals requiring supporting documentation must be submitted by paper with the Appeal Cover Sheet to ensure proper review for reconsideration.
- Texas Children’s Health Plan follows TMHP billing standards for STAR and CHIP claim process. Please refer to your provider contract for details. If any special billing requirements are necessary, Texas Children’s Health Plan will inform the provider.

Required Information for UB-92/UB-04 Claim Forms

- Name and address of facility providing the service
- Member control number (member account number)
- Bill type
- Tax ID number of the facility providing the service
- Coverage period
- Member’s name and address
- Member’s date of birth and sex
- Admission date, admission hour, discharge hour, and discharge status
- Medical record number
- Value codes
- Four digit revenue code
- Description of service
- HCPCS codes (outpatient claims)
- Individual service dates (outpatient claims)
- Number of units
- Billed charge(s) for each revenue code
- Total charge(s)
- Member’s name
- Member’s ID number
- Authorization number, if applicable
- ICD9-diagnosis codes
- DRG code, if applicable
- Surgical procedure code(s), if applicable
- Document control number—providers may use this number for searching or tracking purposes.



If billing for outpatient member surgery revenue codes, please include the corresponding CPT-4 code. The CPT-4 code must be specific, unlisted procedure codes are not applicable. Claims submitted for outpatient member surgery without the CPT-4 code will be denied.

Monthly Capitation Services

Monthly capitation for primary care providers with certain panel sizes may qualify for capitation services in addition to fee-for-service billing. Please refer to your provider contract rate section for specifics or call Texas Children’s Health Plan Provider and Care Coordination at 832-828-1008.

Emergency Services Claims

Emergency services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition including post-stabilization care services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that would a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

STAR Emergency Claim Processing

Claims are received for processing indicating services received in an emergency center identified with service code 450 or place of service 23.

Emergency center claims with revenue code 450 only on the claim are processed with no authorization needed.

Emergency center claims with a subsequent admission are processed as follows:

- Emergency center admissions do not require an authorization for the entire length of stay unless directed by the Medical Director to deny any or a portion of the claim.
- The Health Plan can challenge any portion of an inpatient stay related to an emergency admission that the Medical Director believes was unreasonable and not related to the need to stabilize a patient prior to a transfer or discharge.
- A written notice of determination will be sent to the provider from the Medical Director stating specifically why he/she believes the attending physician's decision was not based on reasonable judgment and will include what medical records or other information will be necessary to conduct a review, or re-review on appeal of emergency services relating to prudent layperson.
- The Medical Director will notify Claims Administration by written notification which services/dates qualify as "unreasonable stabilization."

CHIP Emergency Claim Processing

Claims are received for processing indicating services received in an emergency center identified with service code 450 or place of service 23.

Emergency center claims with revenue code 450 only on the claim are processed with no authorization needed.

Emergency center claims with a subsequent admission are processed as follows:

- Emergency center admissions with one-day length of stay—Process to pay.
- Emergency center admissions with more than one-day length of stay—Pay EC visit and one-day length of stay, all additional days may require authorization.

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 the MCO) 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 the correct MCO within 95 days of the date on the 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.

Clean Claims Payment

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, TCHP 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 un-adjudicated.

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.

Out-of-Network Provider Payments

Texas Children's Health Plan, with an accompanying valid authorization from Texas Children's Health Plan Utilization Management, will be responsible for out-of-network claims for members with care in progress with non-participating providers until member's records, clinical information, and care can be transferred to an in network provider. Out-of-network provider reimbursement will be an amount negotiated between the provider and Texas Children's Health Plan or at the usual and customary rate. Texas Children's Health Plan will be responsible for payment for out-of-network providers who provide covered services to members who move out of the service area through the end of the period for which the state has paid Texas Children's Health Plan for that member's care. Texas Children's Health Plan expects providers billing for out-of-network to submit claims within 95 days from the date of service. Texas Children's Health Plan will pay clean claims submitted by out-of-network care within 30 days from Texas Children's Health Plan's receipt of claim.

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.

Guidelines to filing claims

Claim submissions are required within 95 days from date of service.

You can file your electronic claims several ways:

- | | |
|-----------------------------------|-----------------|
| • Electronic Clearinghouse | Payor ID |
| CHIP–Emdeon and Availity | 76048 |
| CHIP–Legacy | 76048C |
| Medicaid/STAR–Emdeon | 75228 |
| Medicaid/STAR–Availity | TXCSM |
| Medicaid/STAR–Legacy | 76048M |
- Regular or certified paper claims can be mailed to:

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

Claims Questions/Status

In-network providers can check claims status, member eligibility, and a variety of other services online through Provider TouCHPoint. You must sign up for this service. To learn more, contact Provider Care and Coordination at 832-828-1008 or toll-free 1-800-731-8527.

To check status of a claim payment, authorized providers can either:

- Contact Texas Children's Health Plan Provider and Care Coordination Department during regular business hours at 832-828-1004 or toll-free 1-800-731-8527, or
- Submit inquiries in writing to:

Texas Children's Health Plan
Attn: Claims Administration Department
PO Box 300286
Houston, TX 77230-0286

When contacting Texas Children's Health Plan Provider and Care Coordination Department, please be prepared to provide the following information:

- | | |
|--------------------------------|---|
| • Name of the provider | • Provider NPI number |
| • Member ID number and/or name | • Name of physician rendering the service |
| • Date(s) of service | • Amount of claim |
| • Exact problem with claim | |

Claims Appeals

Texas Children's Health Plan claims appeals should be sent to:

Texas Children's Health Plan
Attn: Claims Administration Department
PO Box 300286
Houston, TX 77230-0286

Providers must utilize the Claims Appeal/Resubmission Form for all claims, resubmissions, and appeals, located in section VI, *Helpful Forms*, of this manual.

Provider Portal Functionality

Providers may contact Texas Children's Health Plan via our secure portal at TCHP.US/Providers.

For Claims: Submission of STAR Kids batch claims is available via the Texas Children's Health Plan portal.

Please contact Texas Children's Health Plan's Provider Relations department 1-800-731-8527 for information.

VI. Helpful Forms

Sample Form UB-04

1		2														3a PAT. CNTL. #		4 TYPE OF BILL																														
																3b MED. REC. #																																
																5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH		7																												
8 PATIENT NAME										9 PATIENT ADDRESS										c		d		e																								
10 BIRTHDATE		11 SEX	12 DATE		13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES				22	23	24	25	26	27	28	29 ACCT STATE	30																						
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38		39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT																											
a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	ab	ac	ad																			
42 REV. CD.		43 DESCRIPTION														44 HCPCS / RATE / HIPPS CODE				45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
PAGE		OF		CREATION DATE										TOTALS																																		
50 PRYER NAME						51 HEALTH PLAN ID				52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID																														
58 INSURED'S NAME						59 PREL	60 INSURED'S UNIQUE ID				61 GROUP NAME		62 INSURANCE GROUP NO.																																			
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME																																		
66 DX	67	A	B	C	D	E	F	G	H	68																																						
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73																																									
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING		77 OPERATING		78 OTHER		79 OTHER		QUAL		FIRST																																		
c.		d.		e.		LAST		LAST		LAST		QUAL		FIRST																																		
80 REMARKS		81CC		82		83		84		85		86		87																																		
a		b		c		d		e		f		g		h																																		

Sample Form HCFA 1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA	PICA																		
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)											
CITY			STATE			8. RESERVED FOR NUCC USE			CITY			STATE							
ZIP CODE			TELEPHONE (Include Area Code) ()			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY			
c. RESERVED FOR NUCC USE						11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY			
d. INSURANCE PLAN NAME OR PROGRAM NAME						11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S DATE OF BIRTH MM DD YY			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)							
SIGNED _____						DATE _____						SIGNED _____							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY						15. OTHER DATE QUAL. MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____						17b. NPI _____							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E))												22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A. _____ B. _____ C. _____ D. _____												23. PRIOR AUTHORIZATION NUMBER							
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSON Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____						DATE _____						a. NPI		b. NPI					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



Texas Children's[®] Health Plan

The best decision a family can make.

Claim Appeal Form

Date: _____

Claim Appeal Form

- This form should be used to resubmit a **denied or rejected** claim for reconsideration.
- Please complete in **BLUE or BLACK ink only**.

Section I – Claim Detail

Member name: _____

Member ID number: _____

Date of service: _____

Claim number: _____

Section II – Reason for Resubmission/Appeal

- | | |
|--|--|
| <input type="checkbox"/> Coordination of Benefits | <input type="checkbox"/> NCCI edits (must include medical records) |
| <input type="checkbox"/> Member eligibility | <input type="checkbox"/> Add-on codes |
| <input type="checkbox"/> No Authorization Denials | <input type="checkbox"/> Contract/Rate Discrepancy |
| <input type="checkbox"/> Proof of timely filing attached | <input type="checkbox"/> Credit Balance |
| <input type="checkbox"/> Not a duplicate | <input type="checkbox"/> Hospital Audit Results |
| <input type="checkbox"/> NPI# | <input type="checkbox"/> Medical Records Attached |
| <input type="checkbox"/> W9 | <input type="checkbox"/> Other _____ |

Section III – General Information

Appeal Filing —All Claims Appeals must be filed within 120 days from the date of denial for reconsideration. When filing an appeal, please attach documentation supporting your position.

Electronic Appeals —Electronic claims can be resubmitted electronically if the claim is resubmitted within 95 days from the date of service without incurring a past timely filing denial. Claims outside of the 95 days should be resubmitted on paper with the appropriate proof of timely filing attached.

Appeals can be sent via US mail to

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

You may also use Provider TouCHPOint to submit electronically.
For fax submissions contact your Provider Relations representative.

Prior Authorization Appeals should be sent to Utilization Management Department

Fax: 832-825-8796
Texas Children's Health Plan
Attn: UM Appeals
PO Box 301011, WLS 8390
Houston, TX 77230

CL-0712-002

Prior Authorization Request Form

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
--------------	--------	------	-------

SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (<i>see instructions</i>):	
Requesting Provider's Signature and Date (<i>if required</i>):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__)	Code

Inpatient Outpatient Provider Office Observation Home Day Surgery Other: _____

Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehab Mental Health/Substance Abuse
 Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

Home Health (MD Signed Order Attached? Yes No) (Nursing Assessment Attached? Yes No)
 Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

DME (MD Signed Order Attached? Yes No) (*Medicaid only*: Title 19 Certification Attached? Yes No)
 Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

Rev 10/17

Case Management Referral Form



**Texas Children's
Health Plan**

The best decision a family can make.

Referral for case management

Contact: 832-828-1430

Fax: 832-825-8745

Referring physician:

Date: _____

Office contact information:

Demographics

Patient name: _____

DOB: _____

Height: _____

Weight: _____

TCHP ID: _____

Contact information

Parent/guardian: _____

Home: _____

Work: _____

Cell: _____

Primary language: English Spanish Other

Reason for referral: _____

Disease management

- ADHD
- Asthma
- Diabetes
- End of life
- Complex case management
- Weight management (Keep Fit Program)
- Maternity
- Newborn
- Adolescent transition

Disease specific

- Coordinate follow-up appointments
- Positive lead screen
- Health coaching—smoking cessation
- Missed appointment to _____
- Noncompliance with _____

General

Find specialist _____

Basic needs _____

Help coordinate care with _____

Community resources referral _____

Needs services _____

Social issues _____

Other _____

Please contact me

- Routine contact
- Call office after family contact
- Immediately for clarification

When completed, please FAX TO 832-825-8745.

Primary Care by Specialist Request Form



Primary Care by Specialist Request Form

Member's name Date of birth Member number

Parent/guardian's name Primary HMO PCP name

Specialist name Specialty

Diagnosis

Please write a brief description of the reasons you would like the specialist to provide primary care.

I request the above change and hereby give the specialist noted and my current primary care physician permission to release medical records that may be needed in support of my request.

Member (if over 18)/Parent or guardian

Date signed

I certify that it is medically necessary for me to be this member's primary care physician and that I will provide primary care services for this member to include coordination of all the member's health care needs, preventive care examinations, immunizations, and treatment of minor intercurrent illnesses. I further certify that I will accept the same contractual obligations, rates, and payment methodologies as the primary care provider.

Specialist's signature

Date signed

Specialist's telephone number

FAX TO TCHP AT (832)-825-8750

Date received: _____

Date notified of decision: _____

Review by Medical Director

Approved Denied

List reason:

Signature, Medical Director

Date

Rev 01/09

**Texas Department of Health
Tuberculosis Elimination Division
Report of Case and Patient Services**

Date reported to health department _____ / _____ / _____
Date form sent to region _____ / _____ / _____
Date form sent to central office _____ / _____ / _____

- Initial Report Hospital Admission
 Address Change Name Change (show new name and draw single line through old) Other Change (please circle)

SSN _____ Medicaid # _____ ID# _____ DOB _____ / _____ / _____
MM DD YY

Name _____ (Last) _____ (First) _____ (Middle) AKA _____

Street _____ Apt# _____ City _____ County _____ Zip Code _____ Patient's Tel.# _____

Facility/Care Provider Name _____
Initial Reporting Source Health Dept Private Physician Public Hospital VA Hospital Name of person completing this form _____
 Military Hospital TDCJ Other (Specify) _____

Country of Birth _____ If foreign born, Date of entry into U.S. _____ / _____ / _____	Notice of Arrival of Alien with TB Class <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	Reported at Death <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Death Date _____ / _____ / _____ Was TB cause of death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Reported Out of State or Country <input type="checkbox"/> Yes Specify _____ <input type="checkbox"/> No
Preferred Language _____	ETHNICITY <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	

RACE (check all that apply)
 White Native Hawaiian or Pacific Islander
 Black or African American American Indian or Alaskan Native
 Asian Unknown

OCCUPATION (within past 2 years)
 Unemployed during last 2 yrs Unknown Other
 Employed (If employed, check all that apply)
 Migrant/Seasonal Worker Student Child
 Health Care Worker (Specify) _____ Retiree Disabled
 Correctional Emp Other Occupation Homemaker
 Institutionalized

Resident of Correctional Facility at Time of Dx
If Yes Federal Prison State Prison County Jail City Jail Unknown Incarceration Date _____ / _____ / _____
 Juvenile Correctional Facility ICE Other

Resident of Long Term Care Facility at Time of Dx
If Yes Nursing Home Yes No Unknown Residential Facility Mental Health Residential Facility
 Alcohol/Drug Treatment Facility Hospital-Based Facility Other Long Term Care Facility

Testing activities to find latent TB infections
 Patient referred, TB infection Project targeted testing Individual targeted testing Administrative: Not at risk for TB

POPULATION RISKS <input type="checkbox"/> Low Income <input type="checkbox"/> Inner-city resident <input type="checkbox"/> Foreign born <input type="checkbox"/> Binational (US-Mexico) *Within past 2 years <input type="checkbox"/> Correctional employee* <input type="checkbox"/> Health care worker* <input type="checkbox"/> Prison/Jail inmate* <input type="checkbox"/> Long-term facility for elderly/resident* <input type="checkbox"/> Health care facility/resident* <input type="checkbox"/> Shelter for homeless persons* <input type="checkbox"/> Migrant farm worker* <input type="checkbox"/> None of the above risks apply	MEDICAL RISKS <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Alcohol Abuse (within past year) <input type="checkbox"/> Tobacco use _____ <input type="checkbox"/> Silicosis <input type="checkbox"/> Corticosteroids or other immunosuppressive therapy <input type="checkbox"/> Gastrectomy or jejunioileal bypass <input type="checkbox"/> age \leq 5 years <input type="checkbox"/> Recent exposure to TB (Contact to TB case) <input type="checkbox"/> Contact to MDR-TB case <input type="checkbox"/> Weight at least 10% less than ideal body weight <input type="checkbox"/> Chronic malabsorption syndromes	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Cancer of head <input type="checkbox"/> Cancer of neck <input type="checkbox"/> Drug abuse within past year: <input type="checkbox"/> Injecting <input type="checkbox"/> Non-injecting <input type="checkbox"/> Unknown if injecting <input type="checkbox"/> HIV seropositive (check only if laboratory confirmed) <input type="checkbox"/> Tuberculin skin test conversion within 2 years <input type="checkbox"/> Fibrotic lesions (on chest x-ray) consistent with old, healed TB	<input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Other _____ <input type="checkbox"/> None of these medical risks apply
---	--	--	---

HIV TEST RESULTS
Date HIV Test _____ / _____ / _____
 Positive Negative
 Pending Refused
 Not Offered
Date CD4 Count _____ / _____ / _____
Results CD4 Count _____

TUBERCULIN SKIN TEST Documented history of positive TST? Yes No
_____ / _____ / _____ mm Positive Negative Not Read
_____ / _____ / _____ mm Positive Negative Not Read

PRIOR LTBI TREATMENT Yes No
Start Date _____ / _____ / _____
Stop Date _____ / _____ / _____

FOR TREATMENT OF LTBI ONLY
DOPT: Yes, totally observed No, self-administered Both
DOPT Site: Clinic or medical facility Field Both
Frequency: Daily Twice Weekly Three X's Weekly

_____ / _____ / _____ Date Regimen Start _____ / _____ / _____ Date Regimen Stop
_____ / _____ / _____ Date Restart _____ / _____ / _____ Date Regimen Stop

Isoniazid _____ mgs Other (specify) _____ mgs
 Rifampin _____ mgs Other (specify) _____ mgs
 B6 _____ mgs Prescribed for: _____ months Maximum refills authorized: _____ Physician Signature _____ Date _____

CLOSURE: Date _____ / _____ / _____ Completion adequate therapy _____ # months on Rx _____ # months recommended
 Lost to followup Patient chose to stop Deceased (Cause) _____
 Adverse Drug Reaction Moved out of state/country to: _____
Provider decision: Pregnant Non-TB Other: _____



**Texas Department of Health
Tuberculosis Elimination Division
Report of Case and Patient Services**

Date reported to health department _____ / _____ / _____
Date form sent to region _____ / _____ / _____
Date form sent to central office _____ / _____ / _____

Initial Report Drug Resistance Followup or Medical Review Hospital Admission or Discharge

Name _____ (Last) _____ (First) _____ (Middle) DOB _____ / _____ / _____
MM DD YY

Street _____ Apt# _____ City _____ County _____ Zip Code _____ SSN _____

Facility/Care Provider Name _____
Facility responsible for patient care Public Health Clinic Private Physician Hospital Name of person completing this form _____
 Other (Specify) _____

Signs/Symptoms at DX

Fever Y N
Chills Y N
Cough Y N
Productive Cough Y N
Hemoptysis Y N
Night Sweats Y N
Weight Loss (≥ 10%) Y N
Other: _____

Chest X-Ray

Date _____ / _____ / _____
Results: Normal Abnormal Not Done Unk
If Abnormal, check abnormality
 Cavitory Stable
 Non-cavitory, consistent with TB Worsening
 Non-cavitory, not consistent with TB Improving
Comments: _____ Unknown

If Pediatric TB Case (<15 Years Old)

Country of birth for primary guardians:
Guardian 1) _____
Guardian 2) _____
Patient lived outside US for > 3 months
 Yes No Unknown
If yes, Country: _____

Status New Recurrent Reopen
Prior Therapy Yes No Start Date _____ / _____ / _____
Stop Date _____ / _____ / _____

AFB Smear Results
Current _____ / _____ / _____ Negative Positive
 Pending Not done
Specimen type: sputum urine bronchial washing
 biopsy other

ATS Classification

- 0 No M. TB Exposure, Not TB Infected
- 1 M. TB Exposure, No Evidence of TB Infection
- 2 M. TB Infection, No Disease
- 3 M. TB Infection, Current Disease
- 4 M. TB, No Current Disease
- 5 M. TB Suspect, Diagnosis Pending

If biopsy or other, list anatomic site of specimen: _____
If other than sputa, type of exam _____
Collection date of initial positive AFB smear: _____ / _____ / _____
Collection date of first consistently negative AFB smear: _____ / _____ / _____

Predominant Site: (Class 3, 4)

- Significant Sites other than Predominant**
- | | |
|---|---|
| 00 <input type="checkbox"/> Pulmonary | 30 <input type="checkbox"/> Bone and/or Joint |
| 10 <input type="checkbox"/> Pleural | 40 <input type="checkbox"/> Genitourinary |
| 20 <input type="checkbox"/> Lymphatic | 50 <input type="checkbox"/> Miliary/Disseminated |
| 21 <input type="checkbox"/> Cervical | 60 <input type="checkbox"/> Meningeal |
| 22 <input type="checkbox"/> Intrathoracic | 70 <input type="checkbox"/> Peritoneal |
| 23 <input type="checkbox"/> Other | 80 <input type="checkbox"/> Other (Specify) _____ |

Nucleic Acid Amplification Test
Current _____ / _____ / _____ Negative Positive
 Indeterminate Not done

Other Diagnosis

Treatment for Active TB Disease Weight _____ Height _____
Regimen Start _____ / _____ / _____ Regimen Stop _____ / _____ / _____
Restart _____ / _____ / _____ Stop _____ / _____ / _____

Culture Results
Current _____ / _____ / _____ Negative Positive for M. TB
 Positive for Non-M. TB Pending Not done
Specimen type: sputum urine bronchial washing
 biopsy other

Directly Observed Therapy (DOT) Doses:

Yes No If no, specify reason _____

If biopsy or other, list anatomic site of specimen: _____
Collection date of initial positive MTB culture: _____ / _____ / _____
Collection date of first consistently negative MTB culture: _____ / _____ / _____
Sputum culture conversion documented? Yes No NA
If no, then reason _____

DOT Site: Clinic or other medical facility Field Both

- Frequency:** Daily Twice Weekly Three X's Weekly
- | | |
|--|---|
| <input type="checkbox"/> Isoniazid _____ mgs | <input type="checkbox"/> Rifater _____ mgs |
| <input type="checkbox"/> Rifampin _____ mgs | <input type="checkbox"/> Levofloxacin _____ mgs |
| <input type="checkbox"/> Rifamate _____ mgs | <input type="checkbox"/> Gatifloxacin _____ mgs |
| <input type="checkbox"/> Pyrazinamide _____ mgs | <input type="checkbox"/> Moxifloxacin _____ mgs |
| <input type="checkbox"/> Ethambutol _____ mgs | <input type="checkbox"/> Rifapentine _____ mgs |
| <input type="checkbox"/> Streptomycin _____ mgs | <input type="checkbox"/> Clofazimine _____ mgs |
| <input type="checkbox"/> Ethionamide _____ mgs | <input type="checkbox"/> Cycloserine _____ mgs |
| <input type="checkbox"/> Capreomycin _____ mgs | <input type="checkbox"/> PAS _____ mgs |
| <input type="checkbox"/> Amikacin _____ mgs | <input type="checkbox"/> B6 _____ mgs |
| <input type="checkbox"/> Ciprofloxacin _____ mgs | <input type="checkbox"/> _____ mgs |
| <input type="checkbox"/> Ofloxacin _____ mgs | <input type="checkbox"/> _____ mgs |
| <input type="checkbox"/> Rifabutin _____ mgs | <input type="checkbox"/> _____ mgs |

Susceptibility Results
Date initial susceptibility culture was collected _____ / _____ / _____
Initial culture was resistant to: Isoniazid Rifampin Ethambutol
Date last positive culture was collected _____ / _____ / _____
Last culture was resistant to: Isoniazid Rifampin Ethambutol
 Other quinolone(s) _____
 Other(s) _____

Prescribed for: _____ months Maximum refills authorized: _____

Reason Therapy Extending > 12 months:
Hospitalization Advised: Yes No Control Order _____ / _____ / _____
Quarantine Advised: Yes No Court Action _____ / _____ / _____
Return for chest x-ray: _____ / _____ / _____ Compliant: Yes No
Collect next sputum on: _____ / _____ / _____ Other lab studies: _____ / _____ / _____
Return to MD clinic on: _____ / _____ / _____
Return to Nurse clinic on: _____ / _____ / _____

Closure:

Date _____ / _____ / _____ % doses taken by DOT _____
doses taken _____ # doses recommended _____
months on Rx _____ # months recommended _____

Completion of adequate therapy Lost to followup
 Patient chose to stop Adverse drug reaction
 Deceased (Cause) _____
 Moved out of state/country to: _____
Date referral sent to Austin _____ / _____ / _____
Provider decision: Pregnant Non-TB Other: _____

Nurse Signature _____ Date _____

Physician Signature _____ Date _____

Authorize nurse to obtain informed consent
General Comments: _____

Asthma Action Plan



MY EVERY DAY ASTHMA ACTION PLAN

DATE: ____ - ____ - ____

Patient name: _____
(Optional Patient I.D. Label)

For clinic/office use

GREEN ZONE PLAN

I take this medicine EVERY DAY to keep my ASTHMA in CONTROL:

I FEEL GREAT



When I am in my GREEN ZONE:

- No cough,
- No wheeze,
- No chest tightness
- Peak flow is over _____

_____ (name of medicine) _____ (dose), _____ times a day
 _____ (name of medicine) _____ (dose), _____ times a day

Before vigorous exercise I take _____ (name of medicine) _____ (dose)

Other EVERY DAY medicines I take are:

YELLOW ZONE PLAN



When I am in the YELLOW ZONE:

- Early asthma symptoms
- A slight cough or wheeze
- The start of a cold
- My peak flow is _____ to _____

For QUICK RELIEF of asthma symptoms I take:

_____ (name of medicine) _____ (dose), every ____ to ____ hours

For ASTHMA CONTROL I take:

_____ (name of medicine) _____ (dose), _____ times a day

I also take these medicines:

I CALL MY DOCTOR if symptoms don't get better after ____ days
 I Follow my GREEN ZONE plan when my symptoms go away

RED ZONE PLAN

I AM FEELING BAD



When I am in the RED ZONE:

- A Persistent Cough
- A Persistent Wheeze
- Breathing Fast
- Peak flow under _____

I need medical attention.

For QUICK RELIEF of asthma symptoms I take:

_____ (name of medicine) _____ (dose), every ____ to ____ hours

I add an ORAL STEROID MEDICINE (a pill or syrup that I take by mouth)

○Prednisone ____ mg tabs, ____ tabs ____ times a day for ____ to ____ days

○Prednisolone 15 mg/5ml (Prelone, Orapred), ____ ml ____ times a day for ____ to ____ days

For ASTHMA CONTROL I take:

_____ (name of medicine) _____ (dose), _____ times a day

I also take these medicines:

CALL DR. _____ AT () _____ - _____



DANGER ZONE: CALL 911 or go to nearest Emergency Room if:

- Breathing very hard or fast
 - Breathing so hard I can't walk or talk
 - Sucking in the stomach or ribs to breathe
 - Lips or fingertips look blue
- I NEED IMMEDIATE HELP – CALL 911 or Go to the Emergency Room !



Use a spacer with metered dose inhalers. Rinse mouth after using inhalers.

Avoid asthma triggers including: Smoke, strong chemicals, _____

My next asthma follow-up visit is _____

A Patient Visual Analogue Scale for Rating Severity of Childhood Asthma Episodes, Fritz G, Spiit A, Young A, Klein R, Freedman L. Journal of Asthma, 23(5), 1994 Taylor and Francis Ltd, reprinted by permission of the publisher Taylor & Francis Ltd

Patient name: _____
(Optional Patient I.D. Label)

MI PLAN DE ACCIÓN DIARIO CONTRA EL ASMA

FECHA: ____ - ____ - ____

For clinic/office use

PLAN PARA LA ZONA VERDE

Me siento muy bien



Cuando estoy en la ZONA VERDE:

- No tengo tos
- No respiro de forma agitada
- No siento opresión en el pecho
- El flujo máximo es superior a _____

Tomo este medicamento **TODOS LOS DÍAS** para mantener **EL ASMA BAJO CONTROL**

_____ (nombre del medicamento) _____ (dosis) _____ veces al día

_____ (nombre del medicamento) _____ (dosis) _____ veces al día

Antes de hacer ejercicio intenso, tomo _____ (nombre del medicamento) _____ (dosis)

Otros medicamentos que tomo **TODOS LOS DÍAS:**

PLAN PARA LA ZONA AMARILLA



Cuando estoy en la ZONA AMARILLA:

- Se presentan los primeros síntomas del asma
- Tengo tos leve o respiro de forma algo agitada
- Comienzo a resfriarme
- El flujo máximo es de _____ a _____

Para **ALIVIAR RÁPIDAMENTE** los síntomas del asma, tomo:

_____ (nombre del medicamento) _____ (dosis), cada ____ a ____ horas

Para **CONTROLAR EL ASMA**, tomo:

_____ (nombre del medicamento) _____ (dosis) _____ veces al día

También tomo estos medicamentos:

LLAMO AL MÉDICO si los síntomas no mejoran al cabo de ____ días
Sigo el plan para la ZONA VERDE cuando los síntomas cesan

PLAN PARA LA ZONA ROJA



Me siento mal

Cuando estoy en la ZONA ROJA

- Tengo tos persistente
- Respiro de forma agitada continuamente
- Respiro rápidamente
- Flujo máximo por debajo de _____

Para **ALIVIAR RÁPIDAMENTE** los síntomas del asma, tomo:

_____ (nombre del medicamento) _____ (dosis), cada ____ a ____ horas

También tomo **ESTEROIDES POR VÍA ORAL (en pastilla o jarabe)**

Pastillas de prednisona de ____ mg, ____ pastillas _____ veces al día durante ____ a ____ días

Prednisolona de 15 mg/5ml (Prelone, Orapred), ____ ml _____ veces al día durante ____ a ____ días

Para **CONTROLAR EL ASMA**, tomo:

_____ (nombre del medicamento) _____ (dosis) _____ veces al día

También tomo estos medicamentos:

Necesita atención médica.

LLAMO al DR. _____ AL () _____ - _____



ZONA DE PELIGRO: LLAME AL 911 o vaya a la sala de emergencias más cercana si:

- Respira muy profunda o rápidamente
- Respira con tanta dificultad que no puede caminar o hablar
- Al respirar hunde el estómago o los espacios entre las costillas
- Los labios o los dedos se le ponen azules



NECESITO AYUDA DE INMEDIATO: ¡LLAME al 911 o vaya a una sala de emergencias!

Utilice un espaciador con los medicamentos inhaladores. Enjuáguese la boca después de usar el inhalador.

Evite los factores desencadenantes del asma como: el humo, los productos químicos fuertes, _____

La siguiente consulta para control del asma es el _____

A Pictorial Visual Analogy Scale for Rating Severity of Childhood Asthma Episodes, Fritz G, Spiitt A, Young A, Kless R, Freedman E. Journal of Asthma, 31(6), 1994 Taylor and Francis Ltd, reprinted by permission of the publisher Taylor & Francis Ltd

Texas Vaccines for Children Program: Provider Enrollment Form

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT			
<input type="checkbox"/> Initial enrollment* <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Provider PIN Number _____			
*Contact the Health Services Region (HSR) in your area to obtain PIN			
Name of Facility, Practice, or Clinic: _____			
Provider Name (M.D., D.O., N.P., P.A., or C.N.M.*): _____			
(Last Name)	(First Name)	(MI)	(Title)
Contact: _____			
(Last Name)	(First Name)	(MI)	(Title)
Mailing Address: _____			
(P.O. Box or Street Address)		(City)	(Zip)
Address for Vaccine Delivery: _____			
(Street Address and Suite Number)		(City)	(County) (Zip)
Telephone Number: (____) _____ - _____		Fax Number: (____) _____ - _____	
E-mail Address: _____			
<i>In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:</i>			
1) This office/facility will screen patients for VFC eligibility at all immunization encounters, and administer VFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) is enrolled in Medicaid; (3) has no health insurance; (4) is underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC- eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured), or has insurance with a co-pay or deductible the family cannot meet, (5) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP); (6) is a patient who is served by any type of public health clinic and does not meet any of the above criteria.			
2) This office/facility will maintain all records related to the VFC program, including parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.			
3) This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.			
4) This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)			
5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.			
6) This office/facility may charge a vaccine administration fee to non-Medicaid VFC-eligible patients not to exceed \$14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.			
7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.			
8) This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS, and operate within the VFC program in a manner intended to avoid fraud and abuse.			
9) This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.			
10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.			
_____ (Signature*)		_____ (Date)	
_____ (Print Name and Title)			
* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.			

Texas Department of State Health Services
Immunization Branch



Stock Number E6-102
Revised 12/2007

TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER PROFILE FOR PIN _____

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?
 (Circle one) YES NO

Type of Clinic: (√ check one)

- | | |
|--|---|
| <input type="checkbox"/> Public Health Department/District | <input type="checkbox"/> Private Hospital |
| <input type="checkbox"/> Public Hospital | <input type="checkbox"/> Private Practice (Individual or Group) |
| <input type="checkbox"/> Other Public Clinic | <input type="checkbox"/> Other Private Clinic |

PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1 - 6 years	7 - 18 years	Total
Enrolled in Medicaid.				
Uninsured. (Note: Children enrolled in Health Maintenance Organizations are considered insured)				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that Does Not pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage.)				
(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at public health clinics .				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are NOT TVFC-eligible.				
TOTAL PATIENTS: (Add columns)				

TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Formfirst)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)



Texas Vaccines for Children Program: Provider Enrollment Form

TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST-ADDENDUM FOR PIN _____						
Please list all individuals within the practice who will be administering TVFC supplied vaccine.						
Last Name (List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)



Physician Request for Member Education

Physician Request for Member Education

The member referenced below is not following the standards set by my office for keeping scheduled appointments or calling to cancel missed appointments. I have counseled this member at least 3 times regarding such policies and would like to request further assistance from Texas Children's Health Plan (TCHP).

MEMBER NAME: _____

MEMBER ID #: _____

Please list the dates that the member listed above missed appointments and/or failed to call to cancel appointments in accordance with Physician's office policies. (*Member must have missed at least 3 appointments before submitting request to TCHP.*)

DATES OF MISSED APPOINTMENTS

Please describe the attempts made by Physician's office to correct appointment non-compliance.

DATE OF COUNSELING BY PHYSICIAN	DESCRIPTION OF COUNSELING BY PHYSICIAN

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO SUBSTANTIATE THAT THE MEMBER WAS COUNSELED/EDUCATED ON THE IMPORTANCE OF APPOINTMENT COMPLIANCE (i.e. notes in the medical record, documentation of appointment reminders, etc.)

SIGNATURE OF REQUESTING PHYSICIAN: _____

PRINT NAME: _____

DATE: _____

Please fax form to TCHP Member Services Department at (832) 825-8770. Member education will be completed within 14 days.

Physician Request for Removal of Member from Panel

Physician Request for Removal of Member from Panel

The member referenced below is not following the accepted standards set by our office in order to maintain an effective treatment plan or satisfactory patient/physician relationship. The information below is provided so that we can notify the member of such termination request advising him/her to select a new Primary Care Physician.

Member Name: _____

Member ID #: _____

This member has displayed the following:

- Fraudulent use of services or benefits.
- Threats of physical harm to a provider or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or medically necessary.
- Refusal to accept a treatment or procedure recommended by the provider, as such refusal is incompatible with the continuation of the patient-physician relationship. (The provider should also indicate if he or she believes that no professionally acceptable alternative treatment or procedure exists.)
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- Other behavior which has resulted in serious disruption of the patient-physician relationship.

⇒ Provide details to substantiate the above. The request cannot be processed without this information. (Additional pages may be included if the space below is insufficient.) _____

Date(s) Member was counseled/educated: _____

NOTE: SUPPORTING DOCUMENTATION MUST BE ATTACHED TO SUBSTANTIATE THAT THE MEMBER WAS COUNSELED/EDUCATED ON THE IMPORTANCE OF BEING COMPLIANT. (i.e. medical records, chart notes, incident report, copy of the document that shows the member was called and reminded of the appointment, documentation of no-shows, documentation of recommended treatment plan, counseled, etc.)

The above member has been counseled and educated, and there has not been any improvement or progress. It is necessary for this member to be removed from my panel and to seek medical services elsewhere. I will continue to provide treatment for 30 days from the date the primary HMO notifies the member that selection of another PCP is expected.

Signature of Requesting PCP (Note: It must be the member's PCP on record.)

Print PCP's Name

Please fax request and supporting details/documentation to TCHP Provider and Care Coordination at (832) 825-8750.

CRAFFT Screening Test

CRAFFT SCREENING TEST

A brief screening test for adolescent substance abuse

	YES	NO
1. Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?	_____	_____
2. Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in?	_____	_____
3. Do you ever use alcohol or drugs while you are by yourself, ALONE ?	_____	_____
4. Do you ever FORGET things you did while using alcohol or drugs?	_____	_____
5. Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?	_____	_____
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	_____	_____

Scoring: 2 or more positive items indicate the need for further assessment. Referral guide on reverse.



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CM-0812-098

REFERRAL GUIDE

If an adolescent tests positive for alcohol and/or substance abuse contact the following:

For Texas Children's Health Plan Members please refer to:

Texas Children's Health Plan's Behavioral Health and Substance Abuse Hotline

Medicaid/STAR: 1-800-731-8529

CHIP: 1-800-731-8528

The Right Step (TRS) Central Houston

Phone: 713-528-3709

For non-Texas Children's Health Plan Members, please refer to:

The Council on Alcohol and Drugs Houston

Phone: 713-942-4100 or 1-877-777-8829

Bay Area Council on Drugs and Alcohol

Phone: 281-212-2900 or 1-800-510-3111

Additional free services available:

Palmer Drug Abuse Program (PDAP)

Phone: 281-870-9311

Alcoholics Anonymous

Phone: 713-686-6300

Narcotics Anonymous

Phone: 713-661-4200

To find other substance abuse treatment services in your area please call:

Phone: 1-877-966-3784

CM-0812-098

Behavioral Health Authorization Form



Behavioral Health Prior Authorization Form

Phone Number 832-828-1004 Option #5
 Toll Free Phone Number 1-877-213-5508
 STAR 1-866-959-2555
 CHIP 1-866-959-6555
 STAR Kids 1-800-659-5764
 Fax Number 832-825-8767
 Toll Free Fax Number 1-844-291-7505

Member Information

Plan: CHIP Star Star Kids Date of Request: _____ Admit Date: _____

Request Type: Initial Concurrent

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: () - _____

Service Is: Elective/Routine Expedited/Urgent*

*Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent.

Provider Information

Treatment Provider/Facility/Clinic Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Attending Psychiatrist Name: _____

UR Contact Name: _____ UR Phone#/Fax#: _____

Facility Status: PAR Non-PAR Member Court Ordered? Yes No In Process Court Date: _____

Service Type Requested

Service is for: <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use		
<input type="checkbox"/> Inpatient Psychiatric Hospitalization <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Subacute Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> IOP <input type="checkbox"/> Electroconvulsive Therapy (ECT) <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other - Describe: _____ _____ _____	<input type="checkbox"/> Electroconvulsive Therapy (ECT) <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other - Describe: _____ List Psychological/Neurological Test/Hours Requested: _____ _____

Procedure Code(s) and Description Requested: _____, _____, _____, _____ Days requested (inpatient): _____

Dates of Service Requested _____ through _____ Outpatient Sessions Requested (limit 8 per request): _____

ICD10 Primary Diagnosis Code for Treatment (including Provisional Diagnosis)	
Additional Diagnoses (including any known Medical Diagnoses/Conditions)	
Psychosocial Barriers (formerly Axis IV)	
Drug Testing (date completed/results)	Date completed _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative

VII.

Pharmacy Provider Responsibilities

Texas Children's Health Plan has an arrangement with Navitus Health Solutions, a pharmacy benefit management company, to administer pharmacy benefits for Texas Children's Health Plan STAR and CHIP members. 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 access the Navitus website at www.navitus.com.

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

Drugs eligible for Texas Children's Health Plan reimbursement are listed in the current Texas Listing of National Drug Codes.

Providers can find a list of preferred drugs at www.navitus.com through the provider portal or by calling 1-866-333-2757.

Pharmacy Billing and Claims

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.

- Navitus cycle allows payment within 14 days.
- Weekly pharmacy cycles: Pharmacy payment cycles occur 4 times per month. Cycles run every 7 days from Wednesday morning through the following Thursday night. Pharmacies receive payment for these claims on the 7th day following the close of the cycle. Payments are made to the pharmacy for a clean claim within 14 days.

Compounded Prescriptions

A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order.

The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices.

For Navitus to cover a compound, all active ingredients must be covered on the patient's formulary. In general, drugs used in a compound follow the member's formulary as if each drug component were being dispensed individually. The payer must include compound drugs as a covered benefit for the member for Navitus to allow reimbursement.

Any compounded prescription ingredient that is not approved by the FDA (e.g., Estriol) is considered a non-covered product and will not be eligible for reimbursement.

Please contact Navitus at 1-866-333-2757 to see if a client allows for compound prescriptions.

Processing compound prescriptions

Navitus uses a combination of the claims, compound, and DUR segment to fully adjudicate a compound prescription. Use the Compound Code of 02 (NCPDP field 406-D6 located in the Claim Segment on the payer sheet) when submitting compound claims.

The claim must include an NDC for each ingredient within the compound prescription with a minimum of 2 NDCs and a maximum of 25 NDCs (NCPDP field 447-EC located in Compound Segment).

The claim must include a qualifier of "03" (NDC) to be populated in NCPDP field 448-RE followed by NCPDP field 489-TE (NDCs). If an NDC for a non-covered drug is submitted, the claim will be denied.

If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field). This will allow the claim to pay and the pharmacy will be reimbursed for all drugs except the rejected medication with Clarification Code of 8.

For many Navitus payers, compounds with a cost exceeding \$200 must receive an approved prior authorization from Navitus for coverage to be considered. Forms are available on www.navitus.com.

If a compound includes a drug that requires prior authorization under the member's plan, the prior authorization must be approved before the compound is submitted. Compound Claims forms are available at www.navitus.com

Submit the minutes spent compounding the prescription for reimbursement. The minutes listed are to be populated within NCPDP D.0 field 474-8E (level of effort-DUR segment).

Compound Preparation Time	Value	Reimbursement Amount
1-5 minutes	11	\$10
6-15 minutes	12	\$15
16-30 minutes	13	\$20
31+ minutes	14	\$25

Example of the NCPDP D.0 fields for submitting a compound claim

450-EF	Compound dosage form description code
451-EG	Compound dispensing unit form indicator
452-EH	Compound route of administration
447-EC	Compound ingredient component count
488-RE	Compound product ID qualifier
489-TE	Compound product ID
448-ED	Compound ingredient quantity
449-EE	Compound ingredient drug cost
490-UE	Compound ingredient basis of cost determination
474-8E	DUR/PPS level of effort

How to Find a List of Covered Drugs

Drugs eligible for Texas Children's Health Plan reimbursement are listed in the current Texas Listing of National Drug Codes. Providers can find a list of preferred drugs at www.navitus.com.

How to Find a List of Preferred Drugs

Providers can find a list of preferred drugs at www.navitus.com provider portal.

How to Find a List of PA Required Services and Codes

For current Texas Children's Health Plan required authorizations, providers should always review the online Prior Authorization list located at www.tchp.us/authlist.


Meaning of "PA Not Required" on Returned PA Request Form

A response of PA Not Required is not a guarantee of payment. The service must be a benefit of the member's enrollment in order to be considered for payment. "PA Not Required" does not mean that service is covered.

Process for Requesting a Prior Authorization

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 the Vendor Drug Website, ePocrates, and SureScripts for ePrescribing.

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



Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will be undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

When a prior authorization is required and the provider is not available to submit the PA request, HHSC requires pharmacies to dispense a 72-hour supply as long as the member will not be harmed if the PA is denied and therapy will be discontinued. The 72-hour emergency fill is for any Medicaid STAR recipient. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. This also applies if a PA request was submitted but Navitus could not make a decision within 24 hours of receipt. This procedure should not be used for routine and continuous overrides but can be used more than once if the provider remains unavailable. If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of Inspector General and Navitus' Network's department at 1-608-729-1577 for review.

STAR Program



TEXAS ★ **STAR**
PROGRAM
Your Health Plan ■ Your Choice

VIII.

STAR Program and Objectives

The State of Texas Access Reform (STAR) was created under the provisions of the Social Security Act and the Texas Human Resources Code. The State of Texas and the federal government share the cost of Medicaid. Administration of the program is accomplished through contracts and agreements with providers, MCOs, Institute for Child Health Policy (ICHP), and various state agencies.

In 1995, the Texas Legislature authorized the Texas Health and Human Services Commission (HHSC) to restructure the Texas Medicaid program to incorporate managed care delivery systems. This resulted in development of the STAR program. HHSC handles administration of the STAR program as well as MCO compliance. HHSC is responsible for determining eligibility in the program.

The program goals of STAR are as follows:

- Improve access to care for members.
- Increase quality and continuity of care for enrolled members.
- Decrease inappropriate usage of the health care delivery.
- Enhance member satisfaction.
- Enhance provider satisfaction.
- Ensure appropriate utilization of services.
- Improve cost effectiveness and efficiency of the Medicaid program.

Significant differences between traditional Medicaid and STAR are as follows:

- Primary care providers serve as the patient's medical home.
- Primary care providers initiate referrals and coordinate services within the network.
- Authorization and pre-certification requirements exist for certain procedures and all inpatient admissions.
- MCOs cover certain value added services in addition to Medicaid coverage.
- STAR Help Line is available to enroll member.



IX.

STAR Covered Services

General Description

Texas Children’s Health Plan participates in the STAR program as an MCO through the STAR product. At a minimum, Texas Children’s Health Plan must provide a benefit package to members that include fee-for-service (FFS) benefits currently covered under the Medicaid program. The following information provides an overview of benefits provided for STAR members. Please refer to the current Texas Medicaid Provider Procedures Manual for a more inclusive listing of limitations and exclusions that apply to each benefit category. Copayments are not allowed to be taken from STAR members.

Covered Benefit	Comments
Ambulance services	
Audiology services	Hearing aids for members under age 21 are provided through the TMHP and are not a Health Plan service.
Behavioral health services	<ul style="list-style-type: none"> • Inpatient and outpatient mental health services and outpatient chemical dependency services are covered for members under age 21 (coverage for adults effective September 1, 2010) • Detoxification services • Psychiatry services • Counseling services for adults 21 years of age and over <p><i>Please see the Behavioral Health chapter of this manual for further guidelines.</i></p>
Chiropractic services	Coverage is limited to 12 visits
Dialysis	
Durable medical equipment and supplies	
Emergency services	
Family planning services	<ul style="list-style-type: none"> • May access any family planning provider without network restriction. • Annual family planning visit must include correct family planning modifier.
Home health care services	
Hospital services	All out of network services require authorization.

Covered Benefit	Comments
Laboratory	
Medical checkups	Checkups for members under the age of 21 are covered under the Texas Health Steps program.
Optometry and vision	Envolve Vision: CHIP 1-844-520-3711 STAR 1-844-683-2305
Oral Evaluation and fluoride varnish	For ages 6 months through 35 months as part of the Texas Health Steps visit.
Podiatry	
Prenatal care	Please submit OB notification for all pregnant members.
Primary care services	
Radiology, imaging, and X-rays	No other procedures require prior authorization if performed at in-network facility and by in-network provider.
Specialty physician services	No prior authorization required if specialty physician is in-network.
Therapies—physical, occupational, and speech	Prior authorization not required for initial evaluation.
Texas Health Steps	
Transplantation of organs and tissues	

All out-of-network services, except emergency services, require prior authorization. Please contact the Texas Children’s Health Plan Provider and Care Coordination Department or the Utilization Management Program for most current prior authorization requirements.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A client may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the client’s medical condition or the authorized hours are not commensurate with the client’s medical needs. Per §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Added Benefits for STAR Members

STAR members receive all the benefits of Texas Medicaid fee-for-service (which includes all medically necessary services for children) as well as the following additional benefits for adults.

Annual adult well-checks

An annual adult physical exam performed by the member's primary care provider is an additional benefit of the STAR program for members 21 years of age or older. The annual physical exam is performed in addition to family planning services. The annual examination should be age- and health risk-appropriate and should include all the clinically indicated elements of history, physical examination, laboratory/diagnostic examination, and patient counseling that are consistent with good medical practice.

Removal of the inpatient spell of illness limitation

STAR clients are not limited to the 30-day spell of illness. \$200,000 annual limit on inpatient services does not apply for STAR and STAR+PLUS members.

Unlimited medically necessary prescription drugs for adults

STAR members who are 21 years of age or older receive unlimited medically necessary prescription drugs. The elimination of the 3 prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a member's health-care needs.

Family Planning Services

Family Planning services, including sterilization, are covered STAR member benefits. These services can be provided by any qualified HHSC-approved family planning provider (regardless of whether or not the provider is in network for Texas Children's Health Plan) without the prior approval from the primary care provider or the Health Plan. Family planning providers must deliver family planning services in accordance with the HHSC Family Planning Service Delivery Standards. Family planning services are preventive health, medical, counseling, and educational services that assist members in controlling their fertility and achieving optimal reproductive and general health. Family planning services must be provided by a physician or under physician supervision.

In accordance with the provider agreement, family planning providers must assure clients, including minors, that all family planning services are confidential and that no information will be disclosed to a spouse, parent, or other person without the client's permission. Health care providers are protected by law to deliver family planning services to minor clients without parental consent or notification.

Only family planning patients, not their parents, their spouse or other individuals, may consent to the provision of family planning services. However, counseling should be offered to adolescents, which encourages them to discuss their family planning needs with a parent, adult family member, or other trusted adult.

Sterilization services are a benefit. In the event that a Texas Children's Health Plan member aged 21 years or older chooses sterilization, providers must use the current state-approved sterilization consent form and complete at least 30 days prior to the procedure, with some exceptions related to emergency surgery and premature deliver. These forms and instructions are available in both English and Spanish at www.tmhp.com by clicking on the *Family Planning* link under the *Provider* section.

Providers may fax the completed form to Texas Children's Health Plan at 832-825-8760 or simply include with the completed claim forms.



X.

STAR Value Added Services

	Value Added Service	Description	Harris Jefferson	
Extra Help for Pregnant Women	Pregnancy Essentials Kit & Canvas Tote	<ul style="list-style-type: none"> • Canvas Tote with prenatal essentials for Mom-to-be for 1st trimester • Within 42 days of enrollment 	◆	◆
	Infant Care / Safe Sleep Class	<ul style="list-style-type: none"> • Infant care • Development • Sleep habits <ul style="list-style-type: none"> • SIDs • Gift of a book upon completion 	◆	
	Car Seat Safety Class	<ul style="list-style-type: none"> • Reading safety labels • Installation <ul style="list-style-type: none"> • Appropriate sizing 	◆	
	Childbirth Education Class	<ul style="list-style-type: none"> • Nutrition • Comfort positions • Lamaze Certified Childbirth Educator <ul style="list-style-type: none"> • Childbirth choices • The importance of skin-to-skin contact 	◆	
	Breastfeeding Basics and Beyond Class	<ul style="list-style-type: none"> • Benefits of breastfeeding for both mom and baby 	◆	
	Becoming a Mom Educational Class	<ul style="list-style-type: none"> • Stages of pregnancy and post-delivery • What moms can expect throughout each trimester 	◆	
	Infant CPR Training Class	<ul style="list-style-type: none"> • Non-certified <ul style="list-style-type: none"> • How to respond if your baby is choking 	◆	
	Portable Crib/Playpen	<ul style="list-style-type: none"> • After first postpartum visit 21-56 days after delivery 	◆	◆
Health and Wellness	Asthma Education Gift Card	<ul style="list-style-type: none"> • \$50 Gift Card (Walmart), upon completion of • Series of 6 Asthma Education Classes 	◆	
	Post Hospitalization Follow-up Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of • Post hospitalization visit within 14 days of discharge • Up to 3 times per member 		
	Diabetes Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), up to 3 cards upon completion of each • Annual diabetic eye exam OR • Biannual HbA1c Blood test (every 6 months) OR • Maintain an under 8 HbA1c blood result every 6 months 	◆	◆
	Cervical Cancer Screening Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of screening • Ages 21-64 	◆	◆
	Smoking Cessation Benefit	<ul style="list-style-type: none"> • Up to \$75 per month for stop-smoking products for tobacco dependent parents of members who agree to coaching 	◆	◆
	24 Hour Nurse Help Line	<ul style="list-style-type: none"> • Nurse staffed phone service line available to member 24 hours a day/ 7 days a week 	◆	◆
Extra Help for Families	Dental Health Services	<ul style="list-style-type: none"> • Comprehensive Oral Exam • 2 routine exams per 12 months • Emergency exams • Ages 21 and up <ul style="list-style-type: none"> • X-rays • Fillings • Routine extractions • 2 cleanings per 12 months 	◆	◆
	Diapers	<ul style="list-style-type: none"> • Up to 2 free packs of disposable diapers, upon completion of • Wellchild check at the 12- and 15-month intervals (5th & 6th THSteps) 	◆	◆
	Caregiver Respite Care Services	<ul style="list-style-type: none"> • In-home respite services to relieve unpaid primary caregivers • Limited to 8 hours per year 		
	Extra Help Getting A Ride	<ul style="list-style-type: none"> • TCHP will arrange for transportation through vendor OR • TCHP will offer prepaid Gas Card 	◆	◆
	Parent Training Class	<ul style="list-style-type: none"> • TCHP educators will offer parent training seminars on a variety of topics 		
Stay Active!	TCHP Keep Fit Program	<ul style="list-style-type: none"> • Healthy eating material • At home work-out materials • Quarterly newsletter • Assigned health coach <ul style="list-style-type: none"> • Health / fitness sessions • 10 week Weight Watcher program • Ages 10–18 with BMI of 20+ 	◆	◆
	Soccer Clinics, a partnership with the Houston Dynamo	<ul style="list-style-type: none"> • Participation in a soccer clinic • Two tickets to Dynamo game at BBVA Compass Stadium <ul style="list-style-type: none"> • Ages 7-12 	◆	
	Sports Team Fee Assistance	<ul style="list-style-type: none"> • Enrollment and access to any sports/physical activity program available for the member • Up to \$100/year per member 		
	Sports / School Physical	<ul style="list-style-type: none"> • 1 Annual <ul style="list-style-type: none"> • Ages 15-19 	◆	◆
Family Fun	Water Park Day	<ul style="list-style-type: none"> • Access to a local waterpark for the member and their family 	◆	◆
	Movie Day	<ul style="list-style-type: none"> • A private movie screening of new release at the theater with concessions for the members 	◆	◆
	Sensory-Friendly Movie Days	<ul style="list-style-type: none"> • Brighter lighting • Lower sound <ul style="list-style-type: none"> • Shorter previews • Welcoming/accepting environment 		
	Boys and Girls Club of Greater Houston	<ul style="list-style-type: none"> • Free summer and school year membership 	◆	

XI.

Texas Health Steps Services

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health service for individuals birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps (THSteps). EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing preventive services. In addition, section 1905(r)(5) of the Social Security Act requires that any medically necessary healthcare service listed in the Act be provided to Texas Health Steps clients even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. These additional services are available through the Comprehensive Care Program (CCP).



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

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

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

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

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

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



Goals

The goal of Texas Health Steps is to provide early detection and treatment of medical and dental problems to infants, children, teens, and young adults from birth through age 20 who are currently enrolled in Medicaid. The American Academy of Pediatrics (AAP) schedule has been modified to meet federal and state requirements in regards to the components of the visits at specific ages. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM)

http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx or the Texas Health Steps website <http://www.dshs.state.tx.us/thsteps/default.shtm> for additional detail.

Texas Health Steps services include:

- Medical checkups.
- Dental services (including checkups).
- Hearing services.
- Diagnosis/treatment for defects in hearing, including hearing aids.
- Vision services.
- Diagnosis/treatment for defects in vision including the provision of eyeglasses.
- Comprehensive care program services.
- Support services.

Client Notification of Services/Outreach

Texas Health Steps recipients receive verbal and written information about services available through the Texas Health Steps Program, Texas Children's Health Plan and other agencies.

ACIP Immunization Schedule/THSteps Periodicity Schedule

Medical checkups are covered for members from birth through age 20 in accordance with the Texas Health Steps Periodicity Schedule. The medical checkup periodicity schedule specifies the ages that medical checkups are to be performed and the required screening protocol. In addition to one inpatient newborn checkup, Texas Health Steps recipients can receive 29 medical checkups from birth through age 20. Refer to the TMPPM or Texas Health Steps Periodicity Schedule for detailed information. Acceptance of Texas Health Steps medical checkups (or any other service) is voluntary. Acceptance or refusal of services does not affect eligibility for or benefits of any other Medicaid service. The current Texas Health Steps Periodicity Schedule is available online at <http://www.dshs.state.tx.us/thsteps/providers.shtm>.

Referral Guidelines

Texas Children's Health Plan members can select any Texas Health Steps medical checkup provider whether they are in-network or out-of-network. Members can be referred to Texas Children's Health Plan Member Services for in-network provider assistance and to Texas Health Steps staff, 1-877-847-8377, for out-of-network medical checkup and dental service providers. A referral is not required for Texas Children's Health Plan members to visit a Texas Health Steps medical or dental service provider.

A major objective of the Texas Health Steps Program is diagnosis and treatment of problems discovered during a medical checkup. A provider who performs the medical checkup may also be qualified to provide needed diagnosis and treatment. To establish continuing care of a member, the medical checkup provider can provide treatment for the condition identified. If the Texas Health Steps medical checkup provider is unable to perform the needed follow-up diagnosis and treatment services, the medical checkup provider is then responsible for referring the member to a provider (of the member's choice) who is qualified to perform the required service(s). Members needing follow-up diagnosis and treatment services must be referred by their primary care provider.

Comprehensive Health Screening* - THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents (Birth through 10 Years of Age)																										
*Comprehensive Health Screening is defined as: both an objective screening with the use of standardized procedures or screening tools and a subjective screening of those components when a standardized procedure or screening tool is not required (e.g., visits when audiometric hearing screening is not required). The screening must be age-appropriate and based on recognized national standards such as the National Center for Education in Maternal and Child Health (NCEMCH) Bright Futures. The absence of a symbol indicates that subjective screening is appropriate unless the provider determines that an objective screen or test is necessary. Refer to the Texas Medicaid Provider Procedure Manual (TMPPM) for further detail.																										
Age	History	Measurements					Comprehensive Unclothed Physical Examination	Vision Screening (objective)	Parent Hearing Checklist	Hearing Screening (objective)	Nutritional Screening	Developmental Screening		Mental Health Screening	Screen for/Administer Immunizations Using ACIP Guidelines	Laboratory Tests					TB Screening		Dental Referral	Health Education and Anticipatory Guidance		
		Length	Height	Weight	BMI	Fronto-Occipital Circumference						Blood Pressure	Developmental Screening: ASQ, PEDS, or other standardized tool			Autism Screening: MCHAT or other standardized tool	Newborn Hereditary/Metabolic Testing	Hemoglobin Type	Lead Questionnaire	Blood Lead Screening	Anemia	Hyperlipidemia (as indicated)			Type II Diabetes (as indicated)	TB Risk Screening Tool
Newborn	•	•	•	•	•	•	•	•	•				•	•	•	•	•								•	
3-5 days	•	•	•	•	•	•	•	•	•					•	•	•	•									•
2 weeks	•	•	•	•	•	•	•	•	•					•	•	•	•									•
MONTHS	2	•	•	•	•	•	•	•	•					•	•	•	•									•
	4	•	•	•	•	•	•	•	•					•	•	•	•									•
	6	•	•	•	•	•	•	•	•					•	•	•	•									•
	9	•	•	•	•	•	•	•	•					•	•	•	•									•
	12	•	•	•	•	•	•	•	•					•	•	•	•									•
	15	•	•	•	•	•	•	•	•					•	•	•	•									•
	18	•	•	•	•	•	•	•	•					•	•	•	•									•
	24	•	•	•	•	•	•	•	•					•	•	•	•									•
YEARS	30	•	•	•	•	•	•	•	•					•	•	•	•									•
	3	•	•	•	•	•	•	•	•					•	•	•	•									•
	4	•	•	•	•	•	•	•	•					•	•	•	•									•
	5	•	•	•	•	•	•	•	•					•	•	•	•									•
	6	•	•	•	•	•	•	•	•					•	•	•	•									•
	7	•	•	•	•	•	•	•	•					•	•	•	•									•
	8	•	•	•	•	•	•	•	•					•	•	•	•									•
	9	•	•	•	•	•	•	•	•					•	•	•	•									•
10	•	•	•	•	•	•	•	•					•	•	•	•									•	

Legend of Symbols	
•	Indicates that a component is mandatory and must be completed during the checkup. If a component is not completed at the required age, then the provider must complete it at the next checkup, if it is age-appropriate, or whenever it is medically necessary.
Δ	TB screening: In counties that have been designated as having a high incidence of TB, administer an intradermal skin test at 1 and 4 years of age and the DSHS-approved questionnaire annually beginning at 2 years of age. In all other counties, administer the DSHS-approved questionnaire annually beginning at 1 year of age.

Comprehensive Health Screening* - THSteps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents (11 through 20 Years of Age)

*Comprehensive Health Screening is defined as: both an objective screening with the use of standardized procedures or screening tools and a subjective screening of those components when a standardized procedure or screening tool is not required (e.g., visits when audiometric hearing screening is not required). The screening must be age-appropriate and based on recognized national standards such as the National Center for Education in Maternal and Child Health (NCEMCH) Bright Futures. The absence of a symbol indicates that subjective screening is appropriate unless the provider determines that an objective screen or test is necessary. Refer to the Texas Medicaid Provider Procedure Manual (TMPPM) for further detail.

Age	History	Measurements				Comprehensive Unclothed Physical Examination	Vision Screening (objective)	Hearing Screening (objective)	Nutritional Screening	Mental Health Screening	Screen for/Administer Immunizations Using ACIP Guidelines	Laboratory Tests (as indicated)							TB Screening		Dental Referral	Health Education and Anticipatory Guidance
		Height	Weight	BMI	Blood Pressure							Hemoglobin Type	Anemia	Hyperlipidemia	Diabetes Type II	STD Screening	HIV test	<input type="checkbox"/> PAP Smear	TB Risk Screening Tool	TB Skin Testing		
YEARS	11	•	•	•	•	•					•								Δ	Δ	•	•
	12	•	•	•	•	•	•				•		•						Δ		•	•
	13	•	•	•	•	•					•								Δ		•	•
	14	•	•	•	•	•					•								Δ		•	•
	15	•	•	•	•	•	•	•			•								Δ		•	•
	16	•	•	•	•	•	•				•		•						Δ		•	•
	17	•	•	•	•	•	•				•								Δ		•	•
	18	•	•	•	•	•	•	•			•								Δ		•	•
	19	•	•	•	•	•	•				•								Δ		•	•
	20	•	•	•	•	•	•				•								Δ		•	•

Legend of Symbols

- Indicates that a component is mandatory and must be completed during the checkup. If a component is not completed at the required age, then the provider must complete it at the next checkup, if it is age-appropriate, or whenever it is medically necessary.
- Δ TB screening: In counties that have been designated as having a high incidence of TB, administer an intradermal skin test at 1 and 4 years of age and the DSHS-approved questionnaire annually beginning at 2 years of age. In all other counties, administer the DSHS-approved questionnaire annually beginning at 1 year of age.
- PAP smear screenings should be performed 3 years after the onset of sexual activity or at 21 years of age.

Reimbursement for Texas Health Steps Services

A complete medical checkup is reimbursed at the Medicaid-allowable rate. There is no reimbursement for incomplete medical checkups. Reimbursable procedures that must be performed during a Texas Health Steps medical checkup are listed on the periodicity schedule. Separate reimbursement is allowed for oral evaluation and fluoride (OEFV) varnish for certified providers, administration of vaccines, TB skin tests, point-of care testing for the initial lead screening, and certain developmental screens. Please use appropriate HHSC approved modifiers when forwarding claims for Texas Health Steps visits performed by nurses or nurse practitioners.

In order to qualify for payment, the provider must be certified as a Texas Health Steps provider by HHSC. To enroll as a Texas Health Steps provider, please call Texas Medicaid and Healthcare Partnership (TMHP) for an application at 1-800-925-9126.

Immunizations (based on the immunization schedule established by the Advisory Committee on Immunization Practices) are a federal and state-required component of a Texas Health Steps medical checkup. Texas Health Steps providers are not reimbursed for the costs of vaccines administered during a medical checkup as vaccines are available free-of-charge to providers through the Texas Vaccines for Children (TVFC) program for clients birth through 18 years. The Texas Vaccine for Children Program Provider Enrollment form is located on page 44.

During a medical checkup, providers are reimbursed a separate fee for the administration of each required vaccine given to a Texas Health Steps recipient. Combined antigen vaccines (DTaP-Hib, MMR) are reimbursed as one dose. Recipients are not to be referred to local health departments for their immunizations. Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac) when an immunization is given. Written consent must be obtained by Provider from parent or guardian before any information is included in the registry. The consent is valid until Member becomes 18 years of age (those 18 and older may now consent for their records to be maintained in ImmTrac as well). Provider must verify consent before information is included in ImmTrac. If Provider is unable to verify consent, the Provider will be notified by ImmTrac and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac website: <http://www.immtrac.tdh.state.tx.us/>

As a Texas Children's Health Plan provider, you can fulfill your immunization reporting obligation two ways:

- You can submit the data to Texas Children's Health Plan through claims and we will report it up to ImmTrac for you for Texas Children's Health Plan members.
- You can apply to ImmTrac to submit data directly to the system. You can apply to ImmTrac by filling out the application process that is provided at the ImmTrac website listed above or e-mail ImmTrac at ImmTrac@dshs.state.tx.us.

As a reminder, families who receive financial assistance from HHSC can receive sanctions for failure to obtain, without good cause, medical checkups and immunizations on a timely basis.

A Texas Health Steps medical checkup is to be performed within 90 days of a member's enrollment in an MCO. As a condition for reimbursement, children younger than age 15 must be accompanied by the parent, guardian, or other authorized adult at the medical or dental checkup.

Texas Health Steps Complete Medical Checkup

Providers are required to administer a complete Texas Health Steps medical checkup for members from birth through age 20, in accordance with the Texas Health Steps Periodicity Schedule. Medical checkups that are exceptions to the periodicity schedule are covered if they are medically necessary, the child has an environmental risk, when required to meet federal or state exam requirements, or when needed before a dental procedure requiring general anesthesia.

The required components of a Texas Health Steps medical checkup are:

Comprehensive health and developmental history that includes:

- Nutritional assessment.
- Developmental assessment including the use of standardized screening tools.
- Autism screening.
- Mental health assessment.
- Tuberculosis screening with skin test based on risk.

Comprehensive Unclothed Physical Examination that includes:

- Oral assessment.
- Measurements (height/length, weight, BMI, and infant head circumference).
- Sensory screening (vision and hearing).
- Laboratory tests including blood lead screening and other tests appropriate for age and risk.
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) schedule.
- Health education/anticipatory guidance.
- Dental referral beginning at 6 months of age until the dental home has been established.
- Referral to necessary services (WIC, dental, CCP, family planning, etc).



In regard to the required developmental screening and autism screening, providers must use the ASQ, ASQ:SE or PEDS for developmental screening and M-CHAT for autism screening at ages specified on the Periodicity Schedule and in the Texas Medicaid Provider Procedures Manual. The checkup is not considered complete without the use of these tools at the specified ages. Texas Children's Health Plan offers enhanced reimbursement to its providers who use these screening tools.

The Texas Health Steps program has developed child health record forms that are intended to assist providers in documenting all required components of the medical checkup. Use of the forms is not required, but providers are encouraged to use them. The forms can be found online at: <http://www.dshs.state.tx.us/thsteps/forms.shtm>

The Texas Department of State Health Services (DSHS) Laboratory, located in Austin, performs free laboratory testing on blood specimens collected by all Texas Health Steps medical checkup providers. The DSHS laboratory also furnishes providers with free laboratory collection supplies and postage-paid mailing containers. The DSHS Women's Health Laboratory in San Antonio provides collection supplies and processing for STD tests. Tests which are required to be sent to the DSHS labs include gonorrhea/Chlamydia, hemoglobin, and the initial lead test, with the exception of lead testing performed with a point of care device in the provider's office. For other tests, the client or specimen may be sent to the laboratory of the provider's choice.

For more information concerning your responsibilities as a participating provider with the HHSC STAR program please refer to your Texas Medicaid Provider Procedures Manual located on the TMHP website at www.tmhp.com.

Information concerning the Texas Medicaid Provider Procedures Manual-Texas Health Steps can be accessed at www.tmhp.com.

We also encourage our providers to access the Texas Medicaid Bimonthly and Special Bulletins by going to www.tmhp.com.

Documentation of Completed Texas Health Steps Components and Elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. Comprehensive health and developmental history which includes nutrition screening, developmental and mental health screening and TB screening.
 - A complete history includes family and personal medical history along with 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.
2. Comprehensive unclothed physical examination which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening.
 - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. Immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
 - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV 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.
 - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
 - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
 - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit <https://www.dshs.texas.gov/immunize/tvfc/>.
4. Laboratory tests, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
 - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
 - Anemia screening at 12 months.
 - Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age.
 - HIV screening at 16-18 years.
 - Risk-based screenings include:
 - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.
5. Health education (including anticipatory guidance), is a federally mandated component of the medical checkup and 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.

6. Dental referral every 6 months until the parent or caregiver reports a dental home is established.

- 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.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Texas Health Steps Newborn Services

For a newborn, a checkup must be provided to the newborn prior to his or her discharge from the hospital.

The newborn checkup includes:

- Family and neonatal history.
- Physical exam, including length, weight, and head circumference.
- Vision and hearing screening.
- Health education.
- State-required newborn hereditary/metabolic tests.
- Hepatitis B immunization.

Medical Record Documentation of Texas Health Steps Exams

All information collected during Texas Health Steps checkups must be documented and maintained in the patient medical record for possible review by Texas Children's Health Plan or the Texas Health and Human Services Commission. Age-appropriate Texas Health Steps forms can be found on the Texas Health Steps website at <http://www.dshs.state.tx.us/thsteps/forms.shtm> or the Helpful Forms section of this manual.

Comprehensive Care Program Services

The Comprehensive Care Program (CCP) is an expansion of the Texas Health Steps Program as mandated by the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989. CCP provides treatment for the correction of physical and mental problems or any health care service that is medically necessary, appropriate, and allowable according to federal guidelines, even if the service is not covered under the state plan or not covered due to program limitations. Members must be Medicaid-eligible at the time of service.

Some of the Medicaid providers whose services are available under CCP are outpatient rehabilitation services, licensed dietitians, occupational therapists, orthotic/prosthetic supplies, pharmacists, private duty nursing, speech pathologists, psychiatric hospitals, rehabilitation hospitals, durable medical equipment, medications not covered by the Vendor Drug Program, dental services not covered under the dental program, and rehabilitation hospitals.

CCP services end on the day of the member's 21st birthday.

Texas Health Steps Dental

Pediatric (birth through age 20) dental services for STAR members are covered under the Texas Health Steps program. Routine dental exams and services are available beginning at age 6 months and once every 3-6 months thereafter. These dental services are covered by the Texas Health Steps Dental Program through the member's selected Dental Maintenance Organization (DMO). Neither a referral from the primary care provider nor authorization from Texas Children's Health Plan is necessary for routine dental services. To locate a participating Texas Health Steps dentist, please call the member's DMO.

Texas Health Steps dental providers should submit claims directly to the member's DMO for processing. All Texas Health Steps dental surgery claims will be processed by the member's DMO. Anesthesia and ambulatory care center claims for dental surgeries are covered by the Health Plan and will be processed by Texas Children's Health Plan for Texas Children's Health Plan members.

Texas Health Steps Vision

Each Texas Health Steps checkup includes a vision screen based on the periodicity schedule. The Texas Health Steps Program provides one eye examination per state fiscal year (September through August) and eyeglasses every two years. Any diagnosed conditions or abnormalities of the eye that require additional services beyond the scope of an exam for refractive errors must be referred back to the member's primary care provider. Vision care providers who provide additional services, beyond refractive exams, must have a prior authorization.

Oral Evaluation and Fluoride Varnish (OEFV)

Oral evaluation and fluoride varnish is covered by the Health Plan when provided in the primary care provider's office for children from 6 to 35 months of age. OEFV in the Medical Home offers limited oral health services provided by Texas Health Steps enrolled physicians, physician assistants and advance practice registered nurses. The service is provided in conjunction with the Texas Health Steps medical checkup and includes immediate oral evaluation, fluoride varnish application, dental anticipatory guidance and referral to a dental home. Providers must attend the OEFV training offered by the Department of State Health Services Oral Health Program to be certified to bill for this service. For more information on this service go to: <http://www.dshs.state.tx.us/dental/default.shtm>

In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier when billing fluoride varnish. The oral evaluation/fluoride varnish must be billed with one of the following medical checkup codes—99381, 99382, 99391 or 99392.

Federally Qualified Health Centers should refer to the Medicaid Manual for further instructions on billing.

Reimbursement for Texas Health Steps Services

A listing of the Texas Health Steps codes for each of the different exam types, immunizations, TB skin tests, and newborn hereditary/metabolic tests are included in the Texas Health Steps Quick Reference Guide in this section of the manual and in the current Texas Medicaid Provider Procedures Manual. You must choose the appropriate Texas Health Steps code for the service rendered to the Medicaid client in order to be eligible for reimbursement.

All claims for medical checkups or exception to periodicity must include

- An exam code.
- Immunization and administration codes, if administered.
- TBskin test if administered.
- CLIA waived lead test if performed.
- OEFV if performed.
- Developmental/autism screening at specific ages.

In addition to using the correct Texas Health Steps codes, you should submit these claims using the correct Texas Health Steps modifier. A listing of Texas Health Steps modifiers is included on the Texas Health Steps Quick Reference Guide.

For more information regarding billing and compensation for Texas Health Steps services, providers should consult the Texas Medicaid Provider Procedures Manual.

Texas Health Steps Case Management

Infants, children, teens, and young adults from birth through age 20 can get case management if they:

- Are eligible for Medicaid.
- Have or are at-risk for having a health problem that keeps them from doing things that other kids their age do.
- Need help getting services to keep health problems from getting worse.
- Want case management.

Case managers assist in getting help with:

- Access to needed medical services.
- Family problems.
- Education/school issues.
- Other issues.
- Finding help near where they live.
- Equipment and supplies.

Case managers help by:

- Finding out what families need.
- Making plans to meet those needs.
- Helping families find the services they need near where they live.
- Referring children, women who are pregnant, and their families to community resources and other services.
- Teaching individuals and families how to find and get services they need.
- Following up with families.

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.



Texas Health Steps Quick Reference Guide

Remember: Use Provider Identifier • Use Benefit Code EP1

THSteps Medical Checkup Billing Procedure Codes

THSteps Medical Checkups

99381	99382	99383	99384	99385*
99391	99392	99393	99394	99395*

* For clients who are 18 through 20 years of age, use diagnosis code Z0000 or Z0001.

ICD-10 Diagnosis Codes

Z00110	Routine newborn exam, birth through 7 days
Z00111	Routine newborn exam, 8 through 28 days
Z00129	Routine child exam
Z00121	Routine child exam, abnormal
Z0000	General adult exam
Z0001	General adult exam, abnormal

THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110.

Autism screening with use of the M-CHAT or M-CHAT R/F is reported using procedure code 96110 with U6 modifier.

Mental Health Screening

Mental Health Screening with the use of the PHQ-9, PSC-35, PSC-Y or CRAFFT is reported using procedure code 99420.

Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

Point-of-Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90632 or 90633 [†] with (90460/90461 or 90471/90472)	Hep A
90620 or 90621 with (90460/90461 or 90471/90472)	MenB
90636 with (90460/90461 or 90471/90472)	Hep A/Hep B
90644	Hib-MenCY
90647 [†] or 90648 [†] with (90460/90461 or 90471/90472)	Hib
90649 [†] , 90650 [†] , or 90651 [†] with (90460/90461 or 90471/90472)	HPV
90630, 90654, 90655 [†] , 90656 [†] , 90657 [†] , 90658 [†] , 90685 [†] , 90686 [†] , 90687 [†] or 90688 [†] with (90460/90461 or 90471/90472) or 90660 [†] or 90672 [†] with (90460/90461 or 90473/90474) or 90661 [†] or 90673 with (90471/90472)	Influenza
90670 [†] with (90460/90461 or 90471/90472)	PCV13
90680 [†] or 90681 [†] with (90460/90461 or 90473/90474)	Rotavirus
90696 [†] with (90460/90461 or 90471/90472)	DTaP-IPV
90698 [†] with (90460/90461 or 90471/90472)	DTaP-IPV-Hib

[†] Indicates a vaccine distributed by TVFC

Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

Procedure Codes	Vaccine
90700 [†] with (90460/90461 or 90471/90472)	DTaP
90702 [†] with (90460/90461 or 90471/90472)	DT
90707 [†] with (90460/90461 or 90471/90472)	MMR
90710 [†] with (90460/90461 or 90471/90472)	MMRV
90713 [†] with (90460/90461 or 90471/90472)	IPV
90714 [†] with (90460/90461 or 90471/90472)	Td
90715 [†] with (90460/90461 or 90471/90472)	Tdap
90716 [†] with (90460/90461 or 90471/90472)	Varicella
90723 [†] with (90460/90461 or 90471/90472)	DTaP-Hep B-IPV
90732 [†] with (90460/90461 or 90471/90472)	PPSV23
90733 or 90734 [†] with (90460/90461 or 90471/90472)	MPSV4
90743, 90744 [†] , or 90746 with (90460/90461 or 90471/90472)	Hep B
90748 [†] with (90460/90461 or 90471/90472)	Hib-Hep B

Modifiers

Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

AM (Physician)	SA (Nurse Practitioner)	TD (Nurse)	U7 (Physician Assistant)
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Exception to Periodicity

Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

23 (Unusual Anesthesia)	32 (Mandated Services)	SC (Medically Necessary)
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FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

Vaccine/Toxoids

Use to indicate a vaccine/toxoid *not available* through TVFC and the number of state defined components administered per vaccine.

U1	Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available
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Vaccine Administration and Preventive E/M Visits

Use with THSteps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

25	Significant, separately identifiable evaluation
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Condition Indicator Codes

Use one of the Condition Indicators below if a referral was made.

Indicator	Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

Contact Information

<p>THSteps Medical Checkup Claims Inquiries Call 1-800-757-5691 to obtain answers to questions or determine the status of claims. For managed care clients, contact the client's MCO.</p>	<p>Laboratory The Department of State Health Services (DSHS) Laboratory performs testing for THSteps and NBS clients for the State of Texas. The following provides contact information for ordering laboratory supplies, inquiries on collection, submission and shipping of specimens, and obtaining test results.</p>
<p>THSteps Website General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources. www.dshs.state.tx.us/thsteps/default.shtm THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form may be downloaded from the THSteps website at: www.dshs.state.tx.us/thsteps/forms.shtm Online catalog of THSteps publications: www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm</p>	<p>For THSteps Requests for THSteps laboratory supplies should be made on Form G399 and can be submitted to the DSHS Laboratory Container Preparation Group by:</p> <p>Email: ContainerPrepGroup@dshs.state.tx.us Fax: (512) 776-7672 Phone: (512) 776-7661 or 1-888-963-7111, Ext 7661</p> <ul style="list-style-type: none"> • Specimen shipping questions, call (512) 776-7569 or 1-888-963-7111, Ext 7569 • Specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111, Ext 6236 • Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533 • Online Results: Access THSteps test results online using the Results - Web Portal web application for Clinical Chemistry. To gain access, download, complete, and submit the required access forms. They are available at: www.dshs.state.tx.us/lab/remotedata.shtm • For gonorrhea and chlamydia adolescent screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website: www.dshs.state.tx.us/lab/micCBintro.shtm • For HIV screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website: www.dshs.state.tx.us/lab/sero_about.shtm
<p>THSteps Outreach & Informing Service Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services. 1-877-THSteps (847-8377), Monday to Friday, 8am-6pm</p>	<p>For NBS A written request for Newborn Screening (NBS) specimen collection form (NBS3) is required. To obtain an order form for written requests, call the Container Preparation Group at (512) 776-7661 or 1-888-963-7111, Ext 766.</p> <ul style="list-style-type: none"> • Specimen submission and testing questions, call (512) 776-7333 or 1-888-963-7111, Ext 7333 • Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533 • Online Results: Access Newborn Screening (NBS) test results online using the Texas NBS Web Application. To gain access, download, complete, and submit the required access forms. They are available at: www.dshs.state.tx.us/lab/remotedata.shtm
<p>THSteps Online Provider Education Website Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services. www.txhealthsteps.com</p>	<p>To Report Potential Medicaid Fraud HHSC Client or Provider Fraud Investigations: 1-800-436-6184 https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx</p>
<p>Case Management for Children and Pregnant Women (512) 776-2168 www.dshs.state.tx.us/caseman</p>	<p>Comprehensive Care Program (CCP) Telephone: 1-800-846-7470 Fax: (512) 514-4212</p>
<p>Texas Immunization Registry (ImmTrac) 1-800-348-9158 www.dshs.state.tx.us/immunize/immtrac/default.shtm</p>	<p>Medical Transportation Program (MTP) 1-877-633-8747 www.hhsc.state.tx.us/medicaid/mtp/</p>
<p>Texas Vaccines for Children Program (TVFC) 1-800-252-9152 www.dshs.state.tx.us/immunize/tvfc/default.shtm</p>	<p>Texas Medicaid & Healthcare Partnership (TMHP) General Inquiries Line: 1-800-925-9126 www.tmhp.com</p>
<p>Early Childhood Intervention (ECI) 1-800-628-5115 www.dars.state.tx.us/ecis</p>	
<p>Childhood Lead Poisoning Prevention Program 1-800-588-1248 www.dshs.state.tx.us/lead/default.shtm</p>	
<p>Vendor Drug Program (fee-for-service) The Medicaid Vendor Drug Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through PA Texas. Texas Prior Authorization Call Center: 1-800-728-3927 or online: https://paxpress.txpa.hidinc.com (for prior authorizations of non-preferred drugs only) General information, covered drug list, online pharmacy, and prescriber searches: www.txvendordrug.com www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtm For managed care clients: Contact the client's MCO.</p>	

XII.

Coordination with Non-Health Plan Covered Services

The following services are available to Medicaid (STAR) members, but are not provided by the Health Plan.

Texas Vaccines for Children Program

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

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

Texas Health Steps Environmental Lead Investigation (ELI)

Children with confirmed and persistent elevated blood lead levels may require an environmental lead investigation (ELI) to determine the source of the lead exposure. An ELI may be completed in a client's home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the elevated blood lead level. A lead screening provider is a physician, nurse practitioner, clinical nurse specialist, or physician assistant that conducts blood lead screen(s) for a THSteps client. The lead screening provider may request an ELI by completing Form Pb-101 "Environmental Lead Investigation Request" and submitting it to the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP). If a previous investigation of the current home or primary residence has been performed and there has been a change in the client's residential environment, TX CLPPP will determine whether the criteria are met for an additional ELI. An ELI must be billed with procedure code T1029 and will be restricted to diagnosis codes V1586 and 9849. Laboratory analysis of environmental substances, such as water, paint, or soil, is not a benefit of Texas Medicaid.

Department of Assistive and Rehabilitative Services (DARs) Blind Children's Vocational Discovery and Development Program

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

Assist with developing the confidence and competence needed to be an active part of their community. Provide support and training to you in understanding your rights and responsibilities throughout the educational process. Assist you and your child in the vocational discovery and development process. Provide training to increase your child's independence and ability to participate in vocational related activities. Supply information to families about additional resources.

Texas School Health and Related Services (SHARS)

Texas School Health and Related Services (SHARS) is for children under age 21 with disabilities who need audiology services, nursing services, physician services, occupational therapy, physical therapy, psychological services including assessments, speech therapy services, personal care services, transportation in a school setting, and counseling. For more information on SHARS, refer to the Texas Medicaid Provider Procedures Manual (TMPPM).

Early Childhood Intervention (ECI) Case Management/Service Coordination

Early Childhood Intervention (ECI) is a statewide program combining case management and service coordination for children from birth to age 3 who have disabilities or developmental delays. ECI teaches families how to help children reach their maximum potential through education and therapy services. Federal law requires that providers refer children to ECI within 2 working days of identifying a developmental disability or delay. Providers may call the ECI Referral Line at 1-800-628-5115 to identify an ECI program in the member's area. Brochures and posters are available for provider offices by calling Texas Children's Health Plan Provider and Care Coordination.

Texas Children's Health Plan contracts with qualified ECI providers to provide ECI services to members under age 3 who have been determined eligible for ECI services. Members can self-refer to local ECI service providers without a referral from the member's PCP.

A diagnosis is not required prior to referring a member to ECI. Infants and toddlers from birth to age 3 may be referred if:

- They have medical conditions known to result in delays in development.
- The family suspects delays in one or more areas of development.
- The child exhibits atypical developmental delay.

Local programs conduct free developmental screenings and assess the child for developmental delay and eligibility. Once a child is accepted and enrolled, an Individual Family Service Plan (IFSP) is developed and services are initiated. Texas Children's Health Plan will accept and coordinate services indicated in IFSP, including claims payment for PT/OT/ST. If the child is not accepted into the program, ECI staff will refer the family to other resources.

Mental Health and Mental Retardation Service Coordination and Case Management

Adults and children served through mental health providers approved by the Texas Department of State Health Services (DSHS) are eligible for services including advocacy, assessment, linkage, monitoring, crisis intervention, referral, planning, and coordination of services. Providers servicing clients with mental retardation must additionally have approval of the Department of Aging and Disability Services (DADS.) The priority population served includes service coordination for clients with mental retardation or other related condition, case management for people with serious emotional disturbance, and case management for people with severe persistent mental illness. Providers may obtain information through www.dads.state.tx.us (1-800-458-9858) or DSHS (1-512-206-5810).

DSHS Mental Health Rehabilitation

Rehabilitative services are provided to persons, regardless of age, who have a single severe mental disorder, excluding mental retardation.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) is provided in order to assist eligible members in gaining access to medically necessary medical, social, educational, and other services. It is intended to reduce morbidity and mortality among children, encourage the use of cost-effective health care and health-related care, make referrals to appropriate providers, and discourage over-utilization or duplication of services. Eligible members must meet the following criteria:

- A child must be under age 21, must have a health condition or health risk, must be Medicaid eligible, and must need services to prevent illness or deterioration of his/her condition
- Pregnant women must have 1 or more high-risk medical and/or personal/psychosocial conditions during pregnancy, must be Medicaid-eligible, and must need services to prevent illness or deterioration of their condition.

Case Management for Blind and Visually Disabled

The Texas Commission for the Blind may provide additional case management services for the blind and visually impaired members. This is limited to 1 contact per client, per month. The Southeast Field Headquarters can be reached at 713-948-7960 or 1-800-687-7036.

Tuberculosis Services Provided by Department of State Health Services-Approved Providers

All confirmed or suspected cases of Tuberculosis (TB) must be referred to Department of State Health Services (DSHS) using the forms (TB-400A and TB-400B) and procedures (www.dshs.state.tx.us) for reporting TB adopted by DSHS in accordance with 25 TAC97. The forms can be found in the Helpful Forms section of this manual or on the DSHS website. Directly Observed Therapy and Contact Investigation provided by a DSHS-approved provider is available and can be coordinated with help from a case manager at Texas Children's Health Plan. Texas Children's Health Plan will assist providers in referring to the Local Tuberculosis Control Health Authority (LTCHA) within 1 day of diagnosis for a contact investigation. Texas Children's Health Plan will provide access to member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request. The provider must document the referral to LTCHA in the member's medical records that may be reviewed by DSHS and LTCHA. Providers should copy the appropriate health plan on any referral made to LTCHA.

Texas Children's Health Plan must coordinate with LTCHA to ensure that members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. Texas Children's Health Plan must report any member who is non-compliant, drug-resistant, or who is or may be posing a health threat. These reports must be made to DSHS or LTCHA. Texas Children's Health Plan will cooperate with LTCHA in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

Health and Human Services Commission's Medical Transportation Program (MTP)

What is MTP?

MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
- Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
- Advanced funds to cover authorized transportation services prior to travel

Call MTP:

For more information about services offered by MTP, clients, advocates and providers can call the toll free line at 1-877-633-8747. In order to be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID# or zip code available at the time of the call.

Department of Aging and Disability Services (DADS) Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments). Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death. DADS can be contacted at 1-512-438-3519.

Women, Infant and Children Program

Women, Infant and Children Program (WIC) is a federally funded health-promotion program that provides nutrition education and supplemental foods to pregnant, postpartum (up to 6 months after delivery), and breast-feeding women (up to 12 months after delivery), and their children up to age 5 who have limited incomes and are determined to be at nutritional risk. Individuals in any of the above categories are eligible for WIC services if they are Medicaid-eligible and have a family income less than 185 percent of the federal poverty level. These services are free-of-charge to individuals meeting the income criteria.

Providers are advised to refer every pregnant member at the first prenatal contact and to check WIC status during prenatal visits and at time of delivery.

Members may access WIC services by contacting the nearest WIC agency or calling the Texas WIC information number at 1-800-942-3678. Texas Children's Health Plan Utilization Management Program can assist providers in making arrangements for WIC programs for their patients.

Texas Health Steps Case Management

Infants, children, teens, and young adults from birth through age 20 can get case management if they:

- Are eligible for Medicaid.
- Have or are at-risk for having a health problem that keeps them from doing things that other kids their age do.
- Need help getting services to keep health problems from getting worse.
- Want case management.

Case managers assist in getting help with:

- Access to needed medical services.
- Family problems.
- Education/school issues.
- Financial concerns.
- Finding help near where they live.
- Equipment and supplies.

Case managers help by:

- Finding out what families need.
- Making plans to meet those needs.
- Helping families find the services they need near where they live.
- Referring children, women who are pregnant, and their families to community resources and other services.
- Teaching individuals and families how to find and get services they need.
- Following up with families.

XIII.

Provider Responsibilities

Performing Obligations Within the United States

Provider must perform within the United States all tasks, functions, and responsibilities Provider has either to Texas Children’s Health Plan Members or to Texas Children’s Health Plan.

Provider will not store or transmit outside of the United States any of the following: (1) Protected Health Information, (2) Electronic Protected Health Information, (3) Texas Children’s Health Plan Members’ personal financial information, (4) information obtained pursuant to Provider’s agreement(s) with Texas Children’s Health Plan that is not public information, or (5) information designated “Confidential Information” under state and federal law or the HHSC Uniform Managed Care Contract—available at <http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf>. Provider must not permit the foregoing categories of information—(1) through (5) in the previous sentence—to be moved outside of the United States by any means (physical or electronic) at any time, for any period of time, for any reason. Permitting remote access to such information from a location outside of the United States shall be a violation of this section.

Preventive Health Services

Preventive health services will include, but are not limited to, the following:

- Well child checkups following the Texas Health Steps periodicity schedule for STAR members.
- Immunizations, TB screenings, and other measures for the prevention and detection of disease, including instructions in personal health care practices and information on the appropriate use of medical resources.
- Annual well checkups for all adult Texas Children’s Health Plan members over the age of 21.
- Education of members about their right to self-refer to any network OB/GYN provider for OB/GYN health-related care.

Availability and Accessibility

Texas Children’s Health Plan members are assured timely access to services and availability of providers within the established timeframes as noted below. In all cases below, “day” is defined as a calendar day.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 for adults	Offered to member within 90 days of request
Preventive health care services for children	Offered following Texas Health Steps periodicity schedule
For newly enrolled members from birth through age 20 or for those overdue for Texas Health Steps checkups	Offered no later than 90 days of enrollment
Newborns	In no case later than 14 days of enrollment

24-Hour Availability

Texas Children's Health Plan's contracts with primary care providers state that primary care providers must be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week, for Texas Children's Health Plan members. Arrangements for coverage while off-duty or on vacation are to be made with other participating providers.

Texas Children's Health Plan should be notified of the provider's coverage prior to a leave of absence.

Primary care providers must maintain 1 of the following to receive calls from members after normal business hours:

- Calls may be answered by an answering service which meets the language requirements of the major population groups and which can contact the primary care provider or primary care provider designee. All calls answered by an answering service must be returned within 30 minutes.
- Calls are answered by a recording in the language of each of the major population groups directing the caller to call another number to reach the primary care provider or primary care provider designee. A person, not another recording, must be available to answer the phone at the number indicated in the message.
- Calls may be transferred to another location where a person who is able to contact the primary care provider or the primary care provider designee will answer the phone. All calls answered by an answering service must be returned within 30 minutes.

Unacceptable after-hours coverage includes:

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

Case and Disease Management Program

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

Health Plan care managers enroll members into both disease management and/or case management programs. A referral initiated by the provider is requested to start the services. An assessment and care plan are completed on the patient and referrals and services are provided to the parent/member. The primary care provider is given a care plan for members enrolled in case/disease management programs. Providers should include the care plans in the patient's medical record. Follow-up calls with phone coaching are done monthly to monitor the patient/parent progress with the plan of care. The care manager collaborates closely with the member's primary care provider to share relevant health information whose goal is to positively impact the member's adherence to the medical treatment plan.

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

Providers may request these services by calling the Care Management Department at 832-828-1430. Referral forms are available for download at www.TexasChildrensHealthPlan.org/Providers. Once completed, the forms may be faxed to either the Care Management Department at 832-825-8745 for members with chronic or complex conditions or 832-825-8705 for pregnant members.

Providers Terminating from Plan

Any providers who elect to terminate Texas Children's Health Plan participation must notify Texas Children's Health Plan Provider and Care Coordination by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of the contract with Texas Children's Health Plan. Texas Children's Health Plan will notify any affected current members in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the preceding month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Texas Children's Health Plan to efficiently transfer patients to another primary care provider. Physicians are requested to continue care in progress until all members can be successfully transferred to new primary care providers.

Member Education about Member's Right to Designate an OB/GYN

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

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

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

Member Information about Advance Directives

With advances in medical technology, physicians and the health care team have the ability to save the life of a person who would not otherwise have the chance to live. While this is a benefit to many people, it has also caused problems for the patients and/or families of those who are terminally ill or have irreversible injuries. By prolonging their life, it also prolongs the process of dying.

A member has the right to make decisions about their treatment in the event that the member is not able to make those decisions at the time they are needed. The member's wishes can be recorded on a document called a "Directive to Physician" or indicated by providing a "Medical Power of Attorney."

A member has the right to declare preferences or provide directions for mental health treatment including electroconvulsive or other convulsive treatment and treatment of mental illness with psycho-active medication as defined by the Health and Safety Code as well as emergency mental health treatment. The member can create a document called a "Declaration for Mental Health Treatment." All Texas Children's Health Plan members have the right to informed choices and to refuse treatment or therapy.

Texas Children's Health Plan members have the right to be informed of their health condition, diagnosis, prognosis, and the expected results and associated risks of certain diagnostic, treatment, and therapeutic choices. Texas Children's Health Plan recognizes the right of every individual to self-determination concerning his/her own body. This right may prevail even when the decision of the individual is considered to be unwise or contrary to the individual's best medical interest. Texas Children's Health Plan physicians have a duty to respect this right and must work within the scope of authorized patient consent. Any time there are risks involved, participating physicians should obtain the informed consent of the member, in addition to the required permissive consent. Texas Children's Health Plan strongly recommends that providers encourage members to complete an advanced directive.

Members' Right To a Second Opinion

Texas Children's Health Plan members may access a second opinion regarding any health care service.

A member must be allowed access to a second opinion from a network provider or out-of-network provider, if a network provider is not available, at no additional cost to the member.

Members' Right To Choose a Texas Children's Health Plan Network Pharmacy

Texas Children's Health Plan allows a member to select and have access to any pharmacy in the Navitus network. Texas Children's Health Plan has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the STAR program. For questions related to pharmacy, members should contact Texas Children's Health Plan Member Services at 1-866-959-2555.

Member Education about Member's Right to Eye Health Care Services

Texas Children's Health Plan allows a member to select and have access to, without a primary care provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery.

Authorization for Health Services

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

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

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

Authorizations for in-network specialists are not required.

Effective July 1, 2017. The following services require authorizations:

Medical Authorizations

- 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
- General Anesthesia for Dental Procedures (Facility and Physician) 6 years and under
- 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)
- 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

Behavior Health Authorizations

- 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)

Authorizations for these services must be submitted to Texas Children's Health Plan by faxing the authorization form to 832-825-8760 or calling 832-828-1004. Behavioral Health fax number is 832-825-8767 or 1-844-291-7505. LTSS fax number is 346-232-4757. Utilization Management STAR Kids private duty nursing fax number is 346-232-4757. The primary care provider will remain responsible for ensuring continuity of the member's care by maintaining medical record documentation of treatment rendered. Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

How to Help a Member Find Dental Care

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

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

Behavioral Health Related Services

Primary care providers may provide behavioral health related services within the scope of its practice.

Referral to Network Facilities and Providers

To authorize services, please call 832-828-1004 or fax 832-825-8760.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary or not part of a covered preventive family planning or Texas Health Steps service if both the following conditions are met:

- A specific service or item is provided at the member's request.
- The provider has obtained and kept a written Member Acknowledgement Statement signed by the client that states:

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

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

A provider may bill the following to a member without obtaining a signed Member Acknowledgement Statement:

- Any service that is not a benefit of the Texas Medicaid Program or Texas Children's Health Plan's benefit package (for example, personal care items).
- All services incurred on non-covered days due to lack of eligibility.
- The reduction in payment that is due to the medically needy spend down.
- The provider accepts the member as a private-pay patient.



Private Pay Form Agreement

Providers must advise members that they are accepted as private pay patients at the time the service is provided and that they will be responsible for paying for all services received. The member must sign written notification.

The member is accepted as a private-pay patient pending Medicaid eligibility determination and does NOT become eligible for Medicaid retroactively. The provider is allowed to bill the patient as a private-pay. If the member becomes eligible retroactively, the member should notify the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the patient becomes eligible, the provider MUST refund any money paid by the patient and file Medicaid claims for all services rendered.

PRIVATE PAY AGREEMENT

I, _____ understand that the provider _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any service I receive.

The provider will not file a claim to Medicaid for services provided to me.

Signed: _____

Dated: _____

PACTO DE PAGO PRIVADO

Yo, _____ entiendo que el proveedor _____ me esta aceptando como paciente de pago privado por el periodo de _____, y me hago responsable en pagar por cualquier servicio rendido.

El proveedor no le mandara a Medicaid ningún reclamo por servicios que me rinda.

Nombre: _____

Fecha: _____

Specialty Care Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Texas Children's Health Plan members who have been referred by their primary care provider for specified consultation, diagnosis, and/or treatment. The specialist must communicate with the primary care provider regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the primary care provider. The specialist should also respond to requests from the Texas Children's Health Plan Utilization Management Program for pertinent clinical information that assists in providing a timely authorization for treatment.

Claims submitted for services by specialists for Texas Children's Health Plan members should reference the primary care provider assigned nine-digit Medicaid provider number as the referring provider (Block 17A of the HCFA 1500 claim form).

The provider will maintain such offices, equipment, patient services personnel, and allied health personnel as may be necessary to provide contracted services. If provider is a specialty care physician, the provider will ensure that contracted services are provided under this agreement at the specialty care physician's office during normal business hours, and be available to beneficiaries by telephone 24 hours a day, 7 days a week for consultation on medical concerns.

Responsibility to Verify Member Eligibility Related to Treatment Authorizations

It is the responsibility of the provider who is treating a member under an authorization from Texas Children's Health Plan to verify that the member continues to be a Texas Children's Health Plan member during the treatment period covered by the authorization. Verification of eligibility may be made by:

- Calling Texas Children's Health Plan Member Services at 832-828-1004.
- Visiting Texas Children's Health Plan online at www.TexasChildrensHealthPlan.org/Providers.
- Calling Telephone TouCHPoint at 832-828-1007.

Durable Medical Equipment and Nursing Services

Durable Medical Equipment

Medicaid beneficiaries from birth through age 20 are entitled to all medically necessary durable medical equipment (DME). DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under the age of 21 years if medically necessary. Likewise, time periods for replacement of DME will not apply to Medicaid beneficiaries under the age of 21 years if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

Nursing Services

Medicaid beneficiaries under the age of 21 years are entitled to all medically necessary private duty nursing services and/or home health skilled nursing services. Nursing services are medically necessary when the requested services are nursing services as defined by the Texas Nursing Practices Act and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third-party resource financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must: clearly and consistently describe the beneficiary's current diagnosis, functional status, and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as private duty nursing services or as home health skilled nursing services, depending on whether the beneficiary's nursing needs can be met on a per-visit basis.

Alberto N First Partial Settlement Agreement

The Alberto N First Partial Settlement Agreement requires the MCO to notify members when the MCO is 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 the MCO receives incomplete prior authorization requests. Notices must substantially conform to the sample notices in the UCM and must be written at a sixth-grade reading level with the exception of citations, medical terms, policy, or law.

Notification for Reduction, Denial, Termination of Services Due to no Federal Financial Participation

The notice informing the member of a reduction, denial, or termination of a requested service because there is no federal financial participation for the requested service shall:

- (a) state that this is the basis;
- (b) contain an explanation of the basis for the MCO's decision, applying the state or federal law to the individual's particular request; and
- (c) cite the particular federal law that prohibits federal financial participation for the requested service.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action the MCO intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the basis for the MCO's decision, applying the state and/or federal law to the individual's request;

- A cite to the particular federal law that prohibits federal financial participation for the requested service;
- A toll-free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- Information about accessing medical case management; and,
- An explanation of:
 - The individual's right to a fair hearing;
 - The number of days and date by which the fair hearing must be requested;
 - The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
 - The right to either a written, telephonic, or in-person hearing;
 - The right to examine, at a reasonable time before the date of the hearing, the contents of the case file, and any and all documents to be used by the MCO at the hearing; and,
 - The circumstances under which services will be continued if a hearing is requested.

Notification for Reduction, Denial, Termination of Services Not Medically Necessary

The notice informing the member of a reduction, denial, or termination of a requested service, based on a determination that the requested service is not medically necessary, shall:

- (a) state that this is the basis;
- (b) contain an explanation of the medical basis for the MCO's decision, applying the MCO's policy or the accepted standards of medical practice to the individual's particular medical circumstances; and
- (c) cite the particular state and federal law that supports, or the change in state or federal law that requires, the intended action.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances;
- A cite to the particular state and federal law that supports, or the change in state or federal law that requires, the intended action;
- A toll-free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- Information about accessing medical case management; and,
- An explanation of:
 - The individual's right to a fair hearing;
 - The number of days and date by which the fair hearing must be requested;
 - The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
 - The right to either a written, telephonic, or in-person hearing;
 - The right to either examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing, and
 - The circumstances under which services will be continued if a hearing is requested.

Notification for Incomplete Prior Authorizations

When a request for prior authorization is submitted to the MCO or its contractor with incomplete specific documentation/information: the MCO or its contractor will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, or when possible, the MCO or its contractor will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process. If the documentation/information is not provided with 16 business hours of its request to the Medicaid provider, a letter will be sent to the member explaining that the request cannot be acted upon until the documentation/information is provided, along with a copy of the letter sent to the Medicaid provider describing the documentation/information that needs to be submitted. If the documentation/information is not provided to the MCO or its contractor within 7 days of its letter to the member, a notice will be sent to the member informing the member of its denial of the requested service due to the incomplete documentation/information, and providing the member an opportunity to request a fair hearing.

Alberto N Second Partial Settlement Agreement

The Alberto N Second Partial Settlement Agreement requires the MCO send notification to members regarding denied nursing services and denied private duty nursing services.

Denied Nursing Services

When the Agency or its Contractor determines that the requested nursing services are not nursing services and that the documentation may support authorization of personal care services, the notice denying the nursing services will describe the basis for this determination, in accordance with the paragraph titled Notification for Reduction, Denial, Termination of Services Not Medically Necessary (paragraph 18 of the Partial Settlement Agreement effective April 19, 2002). The notice will include template language briefly describing the Personal Care Services benefit and where and how to request prior authorization for Personal Care Services. The template language to be used is as follows:

“The medical information received may support authorization of Personal Care Services. Personal Care Services are support services provided to Medicaid Beneficiaries under 21 year of age who require assistance with activities of daily living and health related functions because of a physical, cognitive, or behavioral limitation related to their disability to chronic health condition. For more information and to find out how to obtain Personal Care Services for a Medicaid Beneficiary under 21 years of age, you should contact Texas Children’s Health Plan.”

Denied Private Duty Nursing Services

When the MCO or its Contractor determines that the services requested do not support a request for Private Duty Nursing services because the services could be provided on a per-visit basis through Home Health Skilled Nursing services, the notice denying the Private Duty Nursing services will describe the basis for this determination, in accordance with the paragraph titled Notification for Reduction, Denial, Termination of Services Not Medically Necessary (paragraph 18 of the Partial Settlement Agreement effective April 19, 2002). The notice will include template language briefly describing the Home Health Skilled Nursing services benefit and where and how to request prior authorization for Home Health Skilled Nursing services. The template language to be used is as follows:

“The medical information received may support authorization of Home Health Skilled Nursing services. Home Health Skilled Nursing services are nursing services provided on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute care needs or on an ongoing basis to meet chronic needs. For more information and to find out how to obtain Home Health Skilled Nursing services, you should contact Texas Children’s Health Plan.”

Provider Portal

The Texas Children's Health Plan Provider Portal allows providers to view eligibility, claim status, authorizations, receive provider news, access Texas Children's Health Plan specific communications and submit email directly to Texas Children's Health Plan Provider Relations.

Continuity of Care

- Pregnant women information—Texas Children's Health Plan will take special care not to disrupt care in progress for newly enrolled members. Pregnant members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN provider (even if the provider is out of network) through the member's postpartum checkup. A member may change her OB/GYN if she requests.
- Member moves out of service area—Texas Children's Health Plan requests that the member tell us in writing if they move, change their address or phone number, even if these changes are temporary. If a member moves out of the service area, they may no longer be eligible. Our STAR service area includes Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton counties. Texas Children's Health Plan will provide or pay out-of-network providers who provide medically necessary covered services to members who move out of the service area through the end of the period for which capitation has been paid for the member.
- 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 member.

Justification Regarding Out-of-Network Referrals—Including Partners Not Contracted with Texas Children's Health Plan

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-plan specialty referrals are needed. Again, specialty referrals include services which cannot be provided within the Texas Children's Health Plan network. The primary care provider submits authorization form by calling 832-828-1004 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.

Options for Member Non-Compliance

Contact Texas Children's Health Plan Provider and Care Coordination in the event that a member is non-compliant, becomes abusive to you or your staff, and/or continues to demand services that, in your professional judgment, are not medically necessary.

The problem will be researched and resolved. The primary care provider may request, in writing, to Texas Children's Health Plan that a member be transferred to another primary care provider for the following reasons:

- Member is disruptive, unruly, threatening, or uncooperative to the extent that the member's membership seriously impairs the provider's ability to provide services to the member, provided the behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition.
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary and the member has received full informed consent regarding the prescribed treatment course.

Remember, physicians are not allowed to withhold or discriminate in any way in the treatment of a member or to transfer a member from his/her practice because of the health condition of a member or the amount of services provided. A primary care provider cannot transfer a member to another primary care provider without the prior written authorization of the Texas Children's Health Plan Medical Director. Texas Children's Health Plan requests that the physician continue care until Texas Children's Health Plan can successfully transfer the member to a new primary care provider's care.

Primary care providers will not refuse to accept a member as a patient on the basis of health status, previous use of services, or the medical condition of the member.

Reporting Changes to the Health Plan

Providers have a minimum of 30 calendar days to inform Texas Children's Health Plan of any changes to the provider data listed below. Changes not received in writing are not valid. If Texas Children's Health Plan is not informed within the timeframe, Texas Children's Health Plan and its designated claims administrator are not responsible for the potential claims processing and payment errors.

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

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

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

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

Please contact your Provider Relations Manager with reported changes.

XIV.

Coordination with Texas Department of Family and Protective Services

Texas Children's Health Plan works with Texas Department of Family and Protective Services (DFPS) and foster parents to ensure that the at-risk population, both children in the custody and not in the custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out of Texas Children's Health Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the service area. During the transition period and beyond, providers must:

- Provide medical records to DFPS.
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by DFPS.
- Refer suspected cases of abuse or neglect to DFPS.

XV.

Routine, Urgent, and Emergent Services

Definitions

Emergent/Emergency

Emergency services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or and emergency behavioral health condition, including post-stabilization care services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- Requires immediate intervention and/or medical attention without which members would present an immediate danger to themselves or others.
- Which renders members incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency departments are authorized by Texas Children's Health Plan to provide medically necessary and appropriate treatment for any Texas Children's Health Plan member. If a Texas Children's Health Plan member needs to be admitted, the hospital must notify the Texas Children's Health Plan Utilization Management Program within 24 hours of the admission or the next business day, by either calling 832-828-1004 or by faxing the encounter record to 832-825-8760. The primary care provider should also be notified by the hospital about the admission within 24 hours or the next business day.

Urgent

Urgent condition means a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the member's primary care provider or primary care provider designee to prevent serious deterioration of the member's condition or health.

Routine

Routine or preventive (non-emergent) is when postponement of treatment will not endanger life, limb, or mental faculties of patient. That is, a patient's condition permits adequate time to schedule necessary history and physical, laboratory, radiology, or other diagnostic studies on an outpatient basis.

Texas Children's Health Plan is committed to ensuring that members receive a timely and appropriate level of access to all levels of care—emergent, urgent, routine, and preventive. Medical home and specialty providers are expected to deliver care within the following timeframes.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 for adults	Offered to member within 90 days of request
Preventive health care services for children	Offered following Texas Health Steps periodicity schedule
For newly enrolled members under age 21 or for those overdue for Texas Health Steps checkups	Offered as soon as possible and no later than 90 days of enrollment
Newborns	In no case later than 14 days of enrollment

Emergency Prescription Supply

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

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

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

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

- “8” in “Prior Authorization Type Code” (Field 461-EU).
- “8Ø1” in “Prior Authorization Number Submitted” (Field 462-EV).
- “3” in “Days’ Supply” (Field 4Ø5-D5, in the Claim segment of the billing transaction).
- The quantity submitted in “Quantity Dispensed” (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispense.

Call 1-877-908-6023 for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation—Ambulance

Ambulance transport is an emergency service when the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could result in serious impairment, dysfunction, or failure of 1 or more organs or body parts and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

Non-emergency Transportation—Medical Transportation

When a Texas Children's Health Plan member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is a non-emergency service. Non-emergency transports for a Texas Children's Health Plan member with severe disabilities must be to or from a scheduled medical appointment.

A round-trip transfer from the member's home to an outpatient or freestanding dialysis or radiation facility is covered only when the member meets the definition of severely disabled. Severely disabled means that the member's physical condition limits his/her mobility and requires the member to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems, including oxygen or IV infusion. A run sheet or other supporting documentation is required for non-emergency transportation and must clearly state the member's physical condition and severity at the time of the transfer. The run sheet must include the signature of the EMT transporting the client. Non-emergency transfers of members whose condition does not meet the severely-disabled criteria are not covered benefits.

Medicaid Emergency Dental Services

Texas Children's Health Plan is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

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

Medicaid Non-emergency Dental Services:

Texas Children's Health Plan is not responsible for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

Texas Children's Health Plan is responsible for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members age 6 months through 35 months.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.

OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.

Documentation must include all components of the OEFV.

Texas Health Steps providers must assist Members with establishing a Main Dental Home (see page 85) and document Member's Main Dental Home choice in the Members' file.

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 (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.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), 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 (birth through age 20).

What is 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+PLUS, STAR Kids, Medicare-Medicaid Plan (MMP), or Community First Choice Member's home to provide a service will document their arrival time, services and departure time using a telephonic 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 MCO for targeted EVV services.

Do providers have a choice of EVV vendors?

- Provider selection of EVV vendor
 - During the contracting and credentialing process with an MCO, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. A provider is required to use a HHSC-approved EVV vendor as listed on the selection form and select "Initial Selection". Forms are located at (insert link to the most current version of MCO website).
- 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/or will be 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 days after the submission date of the change request.
 - A provider may change EVV vendors only twice in the life of their contract with the MCO. There are only two vendors.
 - A provider will submit an updated copy of the Provider Electronic Visit Verification Vendor System Selection form and select "Vendor Change" when requesting a change to another EVV Vendor.

Can a provider elect not to use EVV?

All Medicaid-enrolled service providers (provider agencies) who provide STAR+PLUS, STAR Kids, Medicaid and Medicare Program (MMP) and CFC services that are subject to EVV are required to use a HHSC approved EVV system to record on-site visitation with the individual/member. Those services include:

- Personal assistance services (PAS)
- In-Home Respite
- Community First Choice – PAS/Habilitation
- Flexible family support services (for STAR Kids only)

Is EVV required for CDS employers?

No. CDS Employers have the option to choose from the following 3 options:

- a. 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.
- b. 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.
- c. 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.

How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors:

DataLogic (Vesta) Software, Inc.
Sales & Training
Email: info@vestaevv.com
Phone: (888) 880-2400
Tech Support: support@vesta.net
Website: www.vestaevv.com

MEDsys Software Solutions, LLC
Texas Dedicated Support and Sales Number
Email: Sales: info@medsyshcs.com
Phone: Support: (877) 698-9392; Option 1
Phone: Sales: (877) 698-9392; Option 2
Website: www.medsyshcs.com

EVV use of Small Alternative Device (SAD) process and required SAD forms

The SAD process can be found at

- <http://www.dads.state.tx.us/evv/formshandbooks.html>
- Forms can be found here: (add link to most current version on MCO website)
- Where do I submit the SAD agreement/order form?
 - The form is submitted to the provider selected EVV vendor
 - DataLogic - email form to: tokens@vestaevv.com or send secure efax to 956-290-8728
 - MEDsys - email form to: tokens@medsyshcs.com or send secure fax to 888-521-0692
- Equipment provided by an EVV vendor to a Provider, if applicable, must be returned in good condition within their control.

What is the HHSC Compliance Plan?

- The HHSC Compliance Plan is 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.

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 non-scheduled) into the EVV system for validation either through an automated system or a manual process. The provider agency must ensure that all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately upon entry, or they will be locked out from the visit maintenance function of the EVV 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.
- 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 MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- 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 on a case-by-case basis.
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System. The MCOs, will review reason code use by their contracted provider agencies to ensure that preferred reason codes are not misused.
- If it is determined that a provider agency has misused preferred reason codes, the provider agency HHSC EVV Initiative Provider Compliance Plan Score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.
- Provider agencies must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System
- Claims are subject to recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System.
- Claims that are not supported by the EVV system will be subject to denial or recoupment.
 - With the exception of HHSC-identified Displaced CM2000 providers, all provider agencies must use the EVV system as the system of record by September 1, 2015.
 - HHSC-identified Displaced CM 2000 providers must use the EVV system as the system of record by February 1, 2015.
- Adherence to the Provider Compliance Plan
 - The MCO Compliance Plan (add link to most current version on MCO website)
 - The HHSC Compliance Plan is located at: <https://www.dads.state.tx.us/evv/complianceplans.html>
- Any Corrective action plan required by an MCO is required to be submitted by the Network Provider to the MCO within 10 calendar days of receipt of request.
- MCO Provider Agencies may be subject to liquidated damages and termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

Provider Complaints and Appeals

Provider Complaints Process to MCO

As a STAR health plan, it is the policy of Texas Children's Health Plan to adhere to State Medicaid Provider Guidelines as defined in the current edition of the Texas Medicaid Provider Procedures Manual. A 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, may file a complaint or appeal with Texas Children's Health Plan. The following information will assist providers in filing.

Complaint Issues

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
Attention: Provider & Care Coordination
Provider and Care Coordination NB 8301
PO Box 301011
Houston, TX 77230-1011
832-828-1008

Texas Children's Health Plan will acknowledge in writing your written complaint within 5 business days and respond to your complaint within 30 days of receipt of the complaint.

How to Submit Complaints Online

Providers may submit complaints online through 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:

TCHPProviderConcerns@TCHP.us

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

Provider Appeal of Claim Determinations

Medical Necessity Appeals/Appeals to a Denial for Service Authorization

If Texas Children's Health Plan denies a provider's request for service authorization due to medical necessity, a provider has 60 calendar days to request an appeal. To request an appeal, please send your written request to:

Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709, WLS 8390
Houston, TX 77230

To assist Texas Children's Health Plan in your request, please state the reason you are requesting your appeal and submit supporting medical documentation. Texas Children's Health Plan will acknowledge in writing your request within 5 business days, and if necessary, request specific medical information to support your appeal. If you do not provide Texas Children's Health Plan with the requested medical information within 10 days, Texas Children's Health Plan will make its decision based on the information provided. Texas Children's Health Plan will respond to your appeal within 30 calendar days of receipt of the appeal.

All appeals of adverse determination for which medical records are not received within 30 calendar days of the filing date will be finalized and the original decision will be upheld. This decision is final and binding, and the provider will have exhausted his/her appeal rights with Texas Children's Health Plan.

Texas Children's Health Plan will allow Community-based Long Term Services and Support providers to appeal claims that have not been paid or denied by the 31st day following receipt.

Expedited Appeals to a Denial for Service Authorization

If Texas Children's Health Plan denies a request for services and a member's medical condition may be jeopardized by the standard 30 calendar day appeal timeframe, a provider may request an expedited appeal review. To request an expedited review, please fax the request to 832-825-8796. Texas Children's Health Plan will respond to expedited appeals involving emergency services or continued hospitalization within 1 business day.

Second Level Appeals to a Denial for Service Authorization

If Texas Children's Health Plan upholds its decision to deny authorization for requested services due to medical necessity, you have a right to request a second review from a different provider in the same or similar specialty. You must file your request within 30 calendar days from receipt of Texas Children's Health Plan appeal decision and set forth in writing good cause for having a particular specialty review.

To request a specialty review, please send your request to:

**Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709 NB 8390
Houston, TX 77230**

Texas Children's Health Plan will complete its specialty review within 15 business days from receipt of your request.

Provider Complaints to Texas Health and Human Services Commission

Providers may file complaints to HHSC if they feel they did not receive full due process from Texas Children's Health Plan. The commission is only responsible for the management of complaints for managed care providers. Appeals/grievances, hearings, or dispute resolution are the responsibility of the Health Plan.

Complaints must be in writing and mailed to:

**Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708
HPM_Complaints@hhsc.state.tx.us**

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

**Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077**

STAR Member Complaint/Appeal Process

Member Complaint Process

Member's Right to File Complaints

Members have the right to use each available complaint process through Texas Children's Health Plan and the state Medicaid program and get a timely response. That includes the right to file a complaint about their health care services, providers, and Texas Children's Health Plan.

A complaint is an expression of dissatisfaction with any aspect of Texas Children's Health Plan's operation, including but not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider, employee, or failure to respect the member's rights.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member.

How to File a Complaint

Members, or their authorized representatives, can file an oral or written complaint with Texas Children's Health Plan. Oral complaints should be filed by calling Member Services at 832-828-1001 or toll-free at 1-866-959-2555. Written complaints should be mailed to the following address:

**Texas Children's Health Plan
Attention: Member Services
PO Box 301011, NB 8360
Houston, TX 77230**

If a member needs assistance filing a complaint, he or she can call Texas Children's Health Plan Member Services at 832-828-1001 or toll-free at 1-866-959-2555. A member advocate is available to help the member file his or her complaint and understand the appeal process.

Texas Children's Health Plan will send the complainant a letter acknowledging receipt of the oral or written complaint within 5 business days. The letter will contain a description of Texas Children's Health Plan's complaint process and timeframes for processing.

Texas Children's Health Plan will investigate the complaint and send the member a resolution letter within 30 calendar days following receipt of the complaint.

Timeframe for Filing a Complaint

Members, or their representatives, may file a complaint at any time.

Timeframe for Resolution of a Complaint

Texas Children's Health Plan will resolve complaints and send a letter to the complainant explaining the resolution within 30 calendar days from the date of receipt of the complaint.

Investigation and resolution of complaints concerning emergencies or the denial of continued stays for hospitalization will be handled in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the member advocate will send a response letter to the member or member's authorized representative with the resolution of the complaint.

If the member has utilized the complaint process and is still not satisfied with the results, the member may also file a complaint with HHSC by writing to, emailing, or calling:

Texas Health and Human Services Commission
Health Plan Operations H-320
Resolution Services
PO Box 85200
Austin, TX 78708-5200
HPM_Complaints@hhsc.state.tx.us
1-800-252-8263



Member's Right to Appeal an Action

Texas Children's Health Plan will notify members in writing of an action or adverse determination on a covered service requested by his or her provider. Adverse determination means a determination by an MCO or utilization review agent that the health care services furnished, or proposed to be furnished to a patient, are not medically necessary or not appropriate. An adverse determination is one type of action.

An action includes:

- The denial or limited authorization of a requested Medicaid service, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial in whole or in part of payment for service.
- The failure to provide services in a timely manner.
- The failure of an MCO to act within timeframes set forth in its contract with HHSC.
- For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to obtain services outside of the network.

Members, or their authorized representative, have the right to use each available appeal process through Texas Children's Health Plan and the state Medicaid program to request an appeal if they disagree with an action.

An appeal is a formal process by which a member, or their authorized representative, requests a review of a Texas Children's Health Plan action. It is considered to be a disagreement with an action.

How to File an Appeal

Members, or their authorized representatives, have the right to file an oral or written request to appeal a notice of action. Oral appeals should be filed by calling Member Services at 832-828-1001 or toll-free at 1-866-959-2555. Written requests for appeals should be mailed to the following address:

Texas Children's Health Plan
Attention: Appeals Department WLS 8390
PO Box 300709
Houston, TX 77230

If a member needs assistance filing an appeal, he or she may call Texas Children's Health Plan Member Services at 832-828-1001 or toll-free at 1-866-959-2555. A member advocate is available to provide assistance and explain the appeal process.

Texas Children's Health Plan will send the appellate a written acknowledgement letter within 5 business days.

If a member files an oral appeal, Texas Children's Health Plan will send with the written acknowledgement letter an appeal form. The appellate must complete and return the appeal form to document the appeal in writing. The appeal request must be signed by the member or their authorized representative.

Timeframe for Filing an Appeal

Members must file a request for appeal within 60 calendar days from receipt of a notice of an action. To ensure continuation of currently authorized services, a member must file an appeal on or before the later of: 1) 10 calendar days following Texas Children's Health Plan's mailing of the notice of the action; or 2) the intended effective date of the proposed action.

Texas Children's Health Plan will continue covered services currently being received by the member if:

- The filing is timely.
- The appeal involves termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original authorization period has not expired and the member requests an extension.

If the appeal decision is adverse to the member, the member may be financially responsible for the services which were the subject of the appeal.

A member also has the right to request a State Fair hearing after exhausting the Texas Children's Health Plan's appeal process.

Timeframe for Resolution of an Appeal

Texas Children's Health Plan will respond to standard appeals in writing within 30 calendar days from the date Texas Children's Health Plan receives the appeal. This timeframe may be extended up to 14 calendar days if:

- The member requests an extension.
- Texas Children's Health Plan advises the member of a need for additional information and that extending the timeframe may be in the member's best interest.

Texas Children's Health Plan will provide written notice of the reason for a delay, if the member did not request the delay. The resolution letter will include:

- A statement of specific medical, dental, or contractual reasons for the resolution.
- The clinical basis for the decision.

Expedited MCO Appeal

Right to an Expedited MCO Appeal

A member, or his/her representative, may request an expedited appeal if he or she believes that taking the time for a standard appeal could jeopardize the member's life or health.

An expedited appeal is when Texas Children's Health Plan is required to make a decision quickly based on the member's health status.

How to File an Expedited Appeal

Expedited appeals may be requested verbally or in writing. To request an expedited appeal, a member or his/her representative should call, fax or mail the appeal to:

Texas Children's Health Plan
Attention: Appeals Department WLS 8390
PO Box 300709
Houston, TX 77230
Fax: 832-825-8796

Texas Children's Health Plan will accept expedited appeals 24 hours a day, 7 days a week. Members or their representatives should provide information supporting the request for an expedited appeal.

Assistance in filing an expedited appeal may be obtained by contacting Texas Children's Health Plan Member Services at 832-828-1001 or 1-866-959-2555. A member advocate is available to provide assistance.

If Texas Children's Health Plan determines that a member's appeal request does not follow the definition of an expedited appeal, it will treat the appeal as a standard appeal. Texas Children's Health Plan will make a reasonable effort to notify the appellate that the appeal is being treated as a standard appeal, with written notice being provided within 2 calendar days.

Resolution Timeframe for an Expedited MCO Appeal

Texas Children's Health Plan must complete its investigation and resolution of an appeal concerning an ongoing emergency or continued hospitalization:

- In accordance with the medical immediacy of the case.
- Not later than 1 business day after Texas Children's Health Plan receives the request for the expedited appeal.

Members will be promptly called with the decision. A letter will also be sent within 2 calendar days of the decision. The letter will include:

- Statement of the specific medical, dental, or contractual reasons for the resolution.
- The clinical basis for the decision.

State Fair Hearing Information

Can I ask for a State Fair Hearing?

Yes. If a Member is dissatisfied with the outcome of the Texas Children's Health Plan appeal process, the Member has the right to request a State Fair Hearing. The Member must first go through the Texas Children's Health Plan appeal process before requesting a State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the Texas Children's Health Plan the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the fair hearing within 120 days of the date on the appeal decision letter. If the Member does not ask for the fair hearing within 120 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member's representative should either send a letter to the health plan at the address below or call 832-828-1001 or 1-866-959-2555.

Texas Children's Health Plan
Attention: Appeals Department NB 8390
PO Box 300709
Houston, TX 77230
Fax: 832-825-8796

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

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

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



XVIII.

STAR Member Eligibility

Eligibility

HHSC, or its administrative services contractor, makes the eligibility determinations for each potential enrollee for the Medicaid Program. The administrative services contractor enrolls and disenrolls eligible individuals. Texas Children's Health Plan is not allowed to induce or accept disenrollment requests from members.

There are 3 primary categories of eligible individuals:

- Families and children—Based on income level, depending on age or pregnancy.
- Cash assistance recipients—Based on receipt of Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).
- Aged and disabled—Based on income level, age, and physical or mental disability.

HHSC makes no guarantees or representations to Texas Children's Health Plan regarding the number of eligible members who will enroll into Texas Children's Health Plan or the length of time members will remain enrolled.

The administrative services contractor electronically transmits to Texas Children's Health Plan new member information and change information applicable to active members on a daily basis.

Texas Children's Health Plan must accept all persons who choose to enroll as members in Texas Children's Health Plan or who are assigned as members by HHSC, without regard to the member's previous coverage, health status, confinement in a health care facility, or any other factor.

Span of Eligibility

Texas' continuous eligibility period for Medicaid is 6 months.

Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call the Your Texas Benefits provider helpline at 1-855-827-3747.
- Call Provider Services at the patient's medical or dental plan.

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid Members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health Events, including diagnosis and treatment, and Lab Results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more.

If you have questions, call 1-855-827-3747 or email ytc-card-support@hpe.com.

Sample Medicaid Verification Form 1027



Texas Health and Human Services Commission/Form H1027-A/09-2007

Medicaid Eligibility Verification
 Confirmación de elegibilidad para Medicaid

	Name of Doctor/Nombre del doctor	Name of Pharmacy/Nombre de la farmacia
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THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
 ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

- Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.
- Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.

Date Eligibility Verified	Verification Method	BIN
	<input type="checkbox"/> Local DCU <input type="checkbox"/> SAVERR Direct Inquiry <input type="checkbox"/> Regional Procedure <input type="checkbox"/> S.O DCU (A & D Staff Only)	610098

Client Name Nombre del Cliente	Date of Birth Fecha de Nacimiento	Client No. Cliente Num.	Eligibility Dates Periodo de Elegibilidad		Medicare Claim No. Núm. de Solicitud de Pago de Medicare	Plan Name and Member Services Toll-Free Telephone No. Nombre del plan y teléfono gratuito de Servicios para Miembros
			From/Desde	Through/Hasta		

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3087) for the current month. I have requested and received Form H1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la identificación para Medicaid (Forma H3087) del presente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el periodo cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

ADVERTENCIA: Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

 Signature-Client or Representative/Firma-Cliente o Representante Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del trabajador	Worker B.J.N	Worker Signature	Date
		X	
Name of Supervisor* (type)/Nombre del supervisor*	Supervisor* B.J.N	Supervisor Signature	Date
		X	

or Authorized Lead Worker/o Trabajador encargado

Medicaid clients do not have to pay bills which Medicaid should pay. It is very important that you tell your doctor, hospital, drugstore, and other health care providers right away that you have Medicaid. If you do not tell them that you have Medicaid, you may have to pay these bills. If you get a bill from a doctor, hospital, or other health care provider, ask the provider why they are billing you. If you still get a bill, call the Medicaid hotline at 1-800-252-8263 for help. If Medicaid will not pay the bill or if Medicaid benefits (services and supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.

Note: Family planning clinics and other providers give free physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling.

El cliente de Medicaid no tiene que pagar cuentas médicas que Medicaid debe pagar. Es muy importante que usted diga inmediatamente a su médico, al hospital, a la farmacia y a otros proveedores de servicios médicos que usted tiene Medicaid. Si no les dice que tiene Medicaid, puede que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital, u otro proveedor de servicios médicos, pregunte por qué le mandó la cuenta. Si todavía le mandan una cuenta, llame al número directo de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir por escrito una audiencia imparcial. La dirección y el número de teléfono aparecen en la carta que recibió.

Nota: Las clínicas de planificación familiar y los otros proveedores ofrecen gratis exámenes físicos, análisis de laboratorio, métodos anticonceptivos (inclusive la esterilización) y consejería sobre los anticonceptivos.

Provider Information/Información para el proveedor

Only those people listed under "CLIENT NAME" have Medicaid coverage. Payment is allowed ONLY for services received during the eligibility dates reflected on the front of this form.

Note: Payment for Family Planning Services is available without the consent of the client's parent or spouse. Confidentiality is required. Family planning drugs, supplies, and services are exempt from the prescription drug and "LIMITED" restrictions.

If there is a health plan named on the front of this form, the client is a member of that health plan in a Medicaid Managed Care program.

Key to terms that may appear on this form:

Limited- Except for family planning services, and for Texas Health Steps (EPSDT), medical screening, dental, and hearing aid services, the client is limited to seeing the doctor and/or limited to using the pharmacy named on the form for drugs obtained through the Vendor Drug Program. In the event of an emergency medical condition as defined below, the "LIMITED" restriction does not apply.

Emergency- The client is limited to coverage for an emergency medical condition. This means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms sufficient severity (including severe pain) such that the absence of immediate medical care could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Hospice- The client is in hospice and waives the right to receive services related to the terminal condition through other Medicaid programs. If a client claims to have canceled hospice, call the local hospice agency or HHSC to verify.

QMB- The Medicaid agency is providing coverage of Medicare premiums, deductible, and coinsurance liabilities, but the client is not eligible for regular Medicaid benefits.

MQMB- The Medicaid agency is providing regular Medicaid coverage as well as coverage of Medicare premiums, deductibles, and coinsurance liabilities.

PE- Medicaid covers only family planning and medically necessary outpatient services.

Women's Health Program- Medicaid coverage is limited to an annual exam, health screenings and contraceptives. The client is not eligible for regular Medicaid benefits.

Note to Pharmacy: Medicaid will pay for more than three prescriptions each month for any Medicaid client who is under age 21, or lives in a nursing facility, or has the STAR/STAR+PLUS Health Plan, or gets services through the Community Living Assistance and Support Services (CLASS), Community Based Alternatives (CBA) and other non-SSI community-based waiver programs. Clients with Medicare who are enrolled in STAR+PLUS may be limited to three prescriptions per month.

Texas Children's Health Plan Identification Card

Texas Children's Health Plan issues a Texas Children's Health Plan identification card (ID) to all its members. When a Texas Children's Health Plan member visits your office, make a copy of both sides of the Texas Children's Health Plan ID Card for your records. Please note that while the Texas Children's Health Plan ID Card identifies a Texas Children's Health Plan member, it does not confirm eligibility or guarantee benefit coverage or payment. If a member presents only his or her Texas Children's Health Plan ID Card to identify his or her health plan and cannot provide a Your Texas Benefits Medicaid Card, providers should then verify the member's current eligibility status through Texas Children's Health Plan. Providers must document this verification in their records and treat these members as if they had presented a Your Texas Benefits Medicaid Card or Medicaid Eligibility Verification (Form 1027).

If a member insists he or she is eligible for Medicaid but cannot produce a Your Texas Benefits Medicaid Card or a Texas Children's Health Plan ID card, providers can verify eligibility through Texas Children's Health Plan or TMHP Contact Center at 1-800-925-9126. Providers must document this verification in their records and treat these members as if they had presented a Your Texas Benefits Medicaid Card or Medicaid Eligibility Verification (Form 1027).

The Texas Children's Health Plan ID Card contains the following information:

Front:

- Member name
- Member ID number
- Member primary care provider
- Effective date for primary care provider
- Primary care provider's phone number

Back:

- Claims address
- Information needed to submit electronic claims

Texas Children's Health Plan
Texas STAR
TEXAS Health and Human Services

Effective Date: RXBIN: 610602
ID: RXPCN: MCD
Group: RXGRP: TCH
Name:
D.O.B.:
PCP Name:
PCP Effective Date:
PCP Phone:
Texas Children's Health Plan Member Services/Servicios para Miembros de Texas Children's Health Plan: 832-828-1001 or toll-free/gratis al 1-800-959-2555, 24 hours/7 days a week / 24 horas/ todos los días.
Nurse Help Line/Línea de Ayuda de Enfermeras: 1-800-686-3831 (TDD); 1-888-259-6952
Behavioral Health & Substance Abuse/Salud mental y abuso de sustancias: 1-800-731-8529, 24 hours/7 days a week / 24 horas/todos los días.
Vision Care/Atención de la vista: Enrolle Vision: 1-844-683-2305 PBM: Navitus: 1-877-908-6023

Members: Please carry this card at all times. Show this card before getting medical care. Call your primary care provider listed on the front of this card for an appointment. **Directions for what to do in an emergency:** In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
Miembros: Favor de llevar esta tarjeta consigo en todo momento. Preséntela antes de recibir atención médica. Llame al proveedor de cuidado primario cuyo nombre aparece en el frente de esta tarjeta para hacer una cita. **Instrucciones en caso de emergencia:** En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.
Navitus Pharmacy Help Desk: 1-877-908-6023.
Providers: Authorization from Texas Children's Health Plan is mandatory for inpatient elective admissions. In case of an emergency, promptly notify the primary care provider at the number listed on the front of this card and Texas Children's Health Plan at:
Provider and Care Coordination:
832-828-1004 (for eligibility, authorizations, benefits, and claims).
Submit claims to: PO Box 300288, Houston, TX 77230
Electronic Claims Filing Number: WebMD: 75228, THIN: TXCSM, Legacy: 76048
This card does not guarantee monthly eligibility.
www.TexasChildrensHealthPlan.org

Medicare

If the member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. (STAR Kids Dual Members).

Options to verify eligibility:

- Automated Inquiry System (AIS Line)/TXMedConnect (TMHP)
- Texas Children's Health Plan Provider Portal — www.tchp.us
- Electronic eligibility verification, e.g. NCPDP E1 Transaction (for Pharmacies only)

Verifying Eligibility Through Texas Children's Health Plan

Providers can verify member eligibility by contacting Texas Children's Health Plan through the internet and by telephone.

Telephone TouCHPoint

Telephone TouCHPoint, a telephone-based automated self-service application, is available 24 hours a day, 365 days a year for providers to request/receive current member eligibility information. A provider can access Telephone TouCHPoint through the provider hotline at 832-828-1004 or directly by calling 832-828-1007. Telephone TouCHPoint gives an immediate verbal response. Providers can also request the response be sent via secure email. The email response is sent within 2 minutes of the request.

Provider TouCHPoint Self Service Portal

Providers can also verify members' eligibility via the internet at Texas Children's Health Plan's website by using Texas Children's Health Plan's Provider TouCHPoint portal. Texas Children's Health Plan's web address is www.TexasChildrensHealthPlan.org. To access Provider TouCHPoint click on the Provider section of the website.

Call Texas Children's Health Plan's Provider and Care Coordination at 832-828-1008 to become a registered user of the portal. Provider TouCHPoint users can check member eligibility, benefits, primary care provider selection, and claims status.

Texas Children's Health Plan Member Services

Providers can call Texas Children's Health Plan Member Services Monday through Friday, 8 a.m. to 5 p.m. at 832-828-1004 to verify members' eligibility and primary care provider selection.



Medicaid Member Rights and Responsibilities

Member Rights

1. You have the right to be treated with respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care provider.
 - d. Change your health plan without penalty.
 - e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with your provider in deciding what health care is best for you.
 - b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
 - e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities

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

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

Member Education about Member's Right to Designate an OB/GYN

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

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

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

Member's Right to Choose a Texas Children's Health Plan Network Pharmacy

Texas Children's Health Plan allows a member to obtain medication from any Texas Children's Health Plan network pharmacy.

Reporting Abuse, Neglect, or Exploitation (ANE)

MCOs 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 MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO 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 DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Reporting Waste, Abuse, or Fraud in STAR by a Provider or Client

If a member suspects a person who receives benefits or a provider (a doctor, dentist, counselor, etc.) has committed waste, abuse, or fraud, he or she has a responsibility and a right to report it.

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

Members can report directly to Texas Children's Health Plan any providers or clients they suspect of waste, abuse, or fraud:

Texas Children's Health Plan
Fraud and Abuse Investigations
PO Box 301011, NB 8302
Houston, TX 77230
832-828-1320 or toll-free at 1-866-959-2555

Do you want to report waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Texas Children's Health Plan
Fraud and Abuse Investigations
PO Box 301011, NB 8302
Houston, TX 77230
832-828-1320 or toll-free at 1-866-959-2555

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

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

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

When reporting about someone who gets benefits, include:

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

Member Selection of a Primary Care Provider

All Texas Children's Health Plan members can choose any primary care provider in the Texas Children's Health Plan network to act as his or her primary care provider or medical home. Each person in the household who is a member may choose the same or a different medical home.

Members who fail to select a primary care provider prior to enrolling in Texas Children's Health Plan will initially receive a Texas Children's Health Plan ID card with no primary care provider indicated. The member is sent a notice along with the ID card requesting that he or she call Member Services to select a provider. Members who fail to select a primary care provider by the 15th day of enrollment are assigned a primary care provider.

Members may change their primary care provider up to 4 times per year. To change a primary care provider, the member calls Member Services at 1-866-959-2555. Limitations to a member selecting a specific primary care provider could include:

- Provider's panel is full.
- Provider does not treat patients their age.
- Provider is no longer participating with Texas Children's Health Plan.

Mothers may select a primary care provider for their unborn child by contacting Texas Children's Health Plan Member Services.

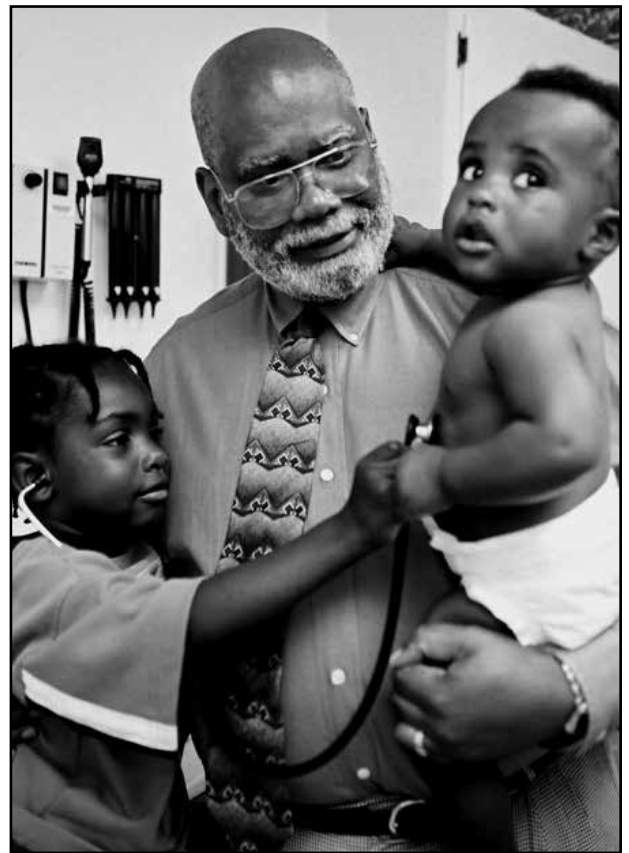
Primary care providers can ask the plan to transfer a member to another primary care provider. We may approve the request if:

- The member does not go to scheduled doctor appointments without calling in advance to cancel.
- The member does not behave well at the doctor's office.

The only time a primary care provider can be changed without the member's prior approval is if:

- The primary care provider is no longer in Texas Children's Health Plan's network.
- The primary care provider no longer accepts Medicaid patients.
- The primary care provider has retired.
- The primary care provider moves.

Providers are prohibited from taking retaliatory action against members.



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STAR Enrollment in Texas Children's Health Plan

Enrollment

Pregnant Women

The Medicaid enrollment broker processes applications for pregnant women within 15 days of receipt. Once an applicant is certified as eligible, a Medicaid ID number will be issued to verify eligibility and to facilitate provider reimbursement.

Texas Children's Health Plan is informed on a daily basis of new pregnant members. Texas Children's Health Plan mails to new members a welcome packet and a Texas Children's Health Plan ID Card. New members who have not selected a primary care provider will be assigned a primary care provider until they pick one.

Texas Children's Health Plan's Maternal Child Representatives are available to assist the new member, as needed, with selecting a primary care provider and/or a prenatal care provider, scheduling prenatal care appointments, or arranging medical transportation services. A brief risk assessment of the woman's pregnancy is requested from all new pregnant members to determine whether the member should be referred to a Texas Children's Health Plan Maternal Child Case Manager.

Maternal Child Case Managers contact prenatal care providers to offer assistance with care coordination for high-risk pregnancies. Physicians and other prenatal care providers are encouraged to make prenatal appointments within 2 weeks or as soon as possible.

To ensure proper billing, physicians should call the TMHP Contact Center at 1-800-925-9126 to obtain the name of the patient's plan if it is not identified on the member's Medicaid Identification Form 3087, or if the member does not present a Texas Children's Health Plan ID Card.

Texas Children's Health Plan requires prior authorization for hospital and professional services beyond the 48/96-hour time limits on vaginal and caesarian deliveries.

Newborns

Newborns will be automatically enrolled in the mother's plan for the first 90 days following birth. The mother's plan will help her choose a primary care provider for the newborn prior to birth or as soon as possible after the birth.

Once a Medicaid eligible baby's birth is reported, HHSC will issue the newborn a Medicaid ID number. If a newborn's state issued Medicaid ID number is not available, Texas Children's Health Plan will issue a temporary "proxy" number for the newborn until the state-issued ID number is available. Pediatric specialists should also use this billing process.

All claims filing deadlines remain the same. To ensure all claims are paid timely and our members receive timely care, Texas Children's Health Plan asks all providers involved in the birth of newborns to assist and encourage the reporting hospitals, birthing centers, etc. to submit birth notifications to the state as soon as possible.

Texas Children's Health Plan will pay newborn claims submitted with the proxy number or with the new Medicaid number.

All newborns remaining in the hospital after mother's discharge, or admitted to level 2 nursery or higher, must have an authorization for inpatient care. Call Texas Children's Health Plan Utilization Management at 832-828-1004 immediately for authorizations.

Automatic Re-enrollment

Texas Children's Health Plan members who lose Medicaid eligibility and then regain their eligibility within 6 months of their termination date will automatically be reassigned, by HHSC, to Texas Children's Health Plan.

Changing Health Plans

STAR members can change health plans as many times as they want, but not more than once a month. If the member is in the hospital, he or she will not be able to change health plans until they have been discharged. If a member is not in the hospital, he or she can change their health plan by calling the Texas STAR Program Help Line at 1-800-964-2777.

If the request to change health plans is received on or before the 15th of the month, the change will take place on the first day of the next month. If the request is received after the 15th of the month, the change will take effect the first day of the second month after that.

For example:

- If the member calls on or before April 15, the change will take place on May 1.
- If the member calls after April 15, the change will take place on June 1.



STAR Member Special Access Requirements

General Transportation and Ambulance/Wheelchair Van

The HHSC Medical Transportation Program (MTP) was created in 1975. MTP is funded with Title XIX and state funds and provides Medicaid members and their attendants non-emergency transportation services (by the most cost-effective modes) to a reasonably close and medically appropriate provider in each HHSC region.

Individuals who are currently Medicaid members and 1 attendant are eligible to receive transportation services. MTP ensures that Medicaid members have transportation to and from facilities that provide appropriate Medicaid covered services when no other means of transportation is available to medical facilities to receive medically necessary Medicaid covered services.

There are 2 ways Texas Children's Health Plan members may get help with transportation needs:

- Ambulance services are covered for all members in emergencies. Severely disabled members whose conditions require ambulance services will be covered with prior approval.
- MTP provides Medicaid clients with transportation to medical offices and doctors for Medicaid-covered health services. This transportation is provided in the most cost-effective manner and at no cost to the member.
- Members may use the service if they have a current Medicaid ID and no other means of transportation. Members on a bus route will be sent a bus token.

MTP requires a two-workday notice for most appointments, and mailing time should be allowed for bus tokens. MTP is designed to improve access to medical care for Texas Medicaid clients. It is not for emergency or taxi services. MTP can be reached at 1-877-633-8747 (toll-free).

If neither option works and a member requires transportation to access health care services, call Texas Children's Health Plan Member Services and they will assist.

Interpreter/Translation Services

Texas Children's Health Plan provides language interpretation services to translate multiple languages. We do this through the Language Line which may be accessed by calling Member Services at 832-828-1001. Member Services will then contact the Language Line as a third-party conversation.

For persons who are deaf or hearing impaired, please call Texas Relay TYY line at 1-800-735-2989 and ask them to call Member Services.

Texas Children's Health Plan will arrange, with 72 hours' prior notice, to have someone who speaks the member's language to meet the patient at the provider's office when they come for their appointment. For members in need of a sign language interpreter, Texas Children's Health Plan will provide an approved interpreter from the American Sign Language Association.

Trained interpreters should be used when technical, medical, or treatment information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

Provider/Care Coordination

Texas Children's Health Plan will assist the provider in coordinating the care and establishing linkages, as appropriate for our members with existing community-based entities and services, including, but not limited to:

- Maternal and child health
- Children with Special Health Care Needs (CSHCN)
- Medically Dependent Children Program (MDCP)
- Interagency Council on Early Childhood Intervention
- In-home family support
- Primary home care
- Members with chronic conditions including asthma, diabetes, and obesity.

Texas Children's Health Plan and providers must ensure that members with disabilities or chronic or complex conditions have access to treatment by a multidisciplinary team when determined to be medically necessary for effective treatment, or to avoid separate and fragmented evaluations and service plans. The teams must include both physician and non-physician providers determined to be necessary by the member's primary care provider for the comprehensive treatment of the member. They must:

- Participate in hospital discharge planning.
- Participate in pre-admissions hospital planning for non-emergency hospitalizations.
- Develop specialty care and support service recommendations to be incorporated into the primary care provider's plan of care.
- Provide information to the member and the member's family concerning the specialty care recommendations.

Health Literacy

An estimated 40-44 million Americans are functionally illiterate and another 50 million are only marginally literate. Nearly half of the functionally literate live in poverty and one-fourth are reported to have physical, mental, or health conditions that prevent them from participating fully in work, school, or housework. Texas Children's Health Plan expects that many of our members have limited ability to understand instructions and read medication bottles. Yet, most people with literacy problems are ashamed and will try to hide this from providers.

Low literacy can mean that your patient may not be able to comply with your medical advice and prescriptions because they do not understand your instructions. Patient materials should be written at a fourth- to sixth-grade reading level. The guidelines provided in this section for communication with interpreters are also good guidelines for communicating with members with limited literacy, especially asking the member to repeat your instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines. Above all else, be sensitive to the embarrassment the member may feel about limited literacy.



Children's Health Insurance Program (CHIP)



CHIP Program and Objectives

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Like Medicaid, SCHIP is administered by the Centers for Medicare and Medicaid Services (CMS) and is jointly funded by the federal government and the states. In 1999, Texas Senate Bill 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the Federal Poverty Level (FPL). Coverage under Phase II of the program began on May 1, 2000. The Health and Human Services Commission (HHSC) was given overall authority for the program.

CHIP covers children in families who have too much income or too many assets to qualify for Medicaid, but cannot afford to buy private insurance. To qualify for CHIP a child must be:

- A U.S. citizen or legal permanent resident.
- A Texas resident.
- Under age 19.
- Uninsured for at least 90 days*.
- Living in a family whose income is at or below 200 percent of FPL.
- Living in a family that passes an asset test if family income is above 150 percent of the FPL.**

* There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom available health insurance costs 10 percent or more of the family's net income. A complete list of the exemptions can be found at www.chipmedicaid.org/english/qualify.asp.

** The asset limit is \$10,000, and includes funds in checking or savings accounts, plus the "countable" value of vehicles.

Most families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay copayments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. The amount that a family is required to contribute to the cost of health care services is capped based on family income.

Coordination with Non-Texas Children's Health Plan Covered Services

Some services are available to CHIP members but are not provided through the Health Plan. These include:

Texas Agency Administered Programs and Case Management Services

Texas Children's Health Plan works with Texas Department of Family and Protective Services (DFPS) and foster parents to ensure the at-risk population, both children in the custody and not in the custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out of Texas Children's Health Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the service area. During the transition period and beyond, providers must:

- Provide medical records to DFPS.
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by DFPS.
- Refer suspected cases of abuse or neglect to DFPS.

Texas Vaccines for Children Program

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

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

Essential Public Health Services

Texas Children's Health Plan is required, through its contractual relationship with HHSC, to coordinate with public health entities regarding the provision of services for essential public health services. Providers must assist Texas Children's Health Plan in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving members.
- Referring to the local public health entity for TB contact investigation and evaluation and preventive treatment of persons whom the member has come into contact.
- Referring to the local public health entity for STD/HIV contact investigation and evaluation as well as preventive treatment of persons with whom the member has come into contact.
- Referring for Women, Infant and Children (WIC) services and information sharing.
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data.
- Cooperating with activities required by public health authorities to conduct the annual population and community based needs assessment.

CHIP Covered Services

There is no lifetime maximum on benefits; however, annual enrollment period or lifetime limitations do apply to certain service, as specified in the following chart. There is no spell of illness limitation. Refer to the most current prior authorization document for a list of services requiring prior authorization.

Covered Benefit	Limitations	Copayments
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</p> <p>Services include:</p> <ul style="list-style-type: none"> • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care. • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; 	<ul style="list-style-type: none"> • Requires authorization for non-emergency care and care following stabilization of an emergency condition. • Requires authorization for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. 	<p>Applicable level of inpatient copay applies.</p>



Covered Benefit	Limitations	Copayments
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- ultrasounds; and
- histological examination of tissue samples.
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - cleft lip and/or palate; or
 - severe traumatic, skeletal, and/or congenital craniofacial deviations; or
 - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment.
- Surgical implants
- Other artificial aids including surgical implants
- Inpatient services for a mastectomy and breast reconstruction include:
 - all stages of reconstruction on the affected breast;
 - surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12 month period limit

**Skilled Nursing Facilities
(Includes Rehabilitation Hospitals)**

Services include, but are not limited to, the following:

- Semi-private room and board
- Regular nursing services
- Rehabilitation services
- Medical supplies and use of appliances and equipment furnished by the facility

- Requires authorization and physician prescription.
- 60 days per 12-month period limit.

None

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center

Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting:

- X-ray, imaging, and radiological tests (technical component)
- Machine diagnostic tests

- May require prior authorization and physician prescription.

Applicable level of copay applies

None for preventive services

Applicable level of copay applies to generic and brand name drugs

Covered Benefit

Limitations

Copayments

- Laboratory and pathology services (technical component)
- Ambulatory surgical facility services
- Drugs, medications, and biologicals
- Casts, splints, dressings
- Preventive health services
- Physical, occupational, and speech therapy
- Renal dialysis
- Respiratory services
- Radiation and chemotherapy
- Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
- Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.
- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
 - dilation and curettage (D&C) procedures;
 - appropriate provider-administered medications;
 - ultrasounds; and
 - histological examination of tissue samples.
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - cleft lip and/or palate; or
 - severe traumatic, skeletal, and/or congenital craniofacial deviations; or
 - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment.
- Surgical implants
- Other artificial aids including surgical implants
- Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
 - all stages of reconstruction on the affected breast;
 - surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit

Covered Benefit

Limitations

Copayments

Physician/Physician Extender Professional Services

Services include, but are not limited to the following:

- American Academy of Pediatrics recommended well child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
- Physician office visits, inpatient, and outpatient services
- Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation
- Medications, biologicals, and materials administered in physician's office
- Allergy testing, serum, and injections
- Professional component (in/outpatient) of surgical services, including:
 - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
 - Administration of anesthesia by physician (other than surgeon) or CRNA
 - Second surgical opinions
 - Same-day surgery performed in a hospital without an overnight stay
 - Invasive diagnostic procedures such as endoscopic examinations
- Hospital-based physician services (including physician-performed technical and interpretive components)
- Physician and professional services for a mastectomy and breast reconstruction include:
 - all stages of reconstruction on the affected breast;
 - surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.

Applicable level of copay applies

Copays do not apply to preventive visits or to prenatal visits after the first visit.

Covered Benefit

Limitations

Copayments

- support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
- Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:
 - dilation and curettage (D&C) procedures;
 - appropriate provider-administered medications;
 - ultrasounds; and
 - histological examination of tissue samples.
 - Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - cleft lip and/or palate; or
 - severe traumatic, skeletal, and/or congenital craniofacial deviations; or
 - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment.

Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies

Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:

- Orthotic braces and orthotics
- Dental devices
- Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses
- Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease
- Other artificial aids including surgical implants
- Hearing aids
- Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit.
- Diagnosis-specific disposable medical

- May require prior authorization and does require physician prescription.
- \$20,000 per 12-month period limit for DME prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).

None



Covered Benefit	Limitations	Copayments
supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.		
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: <ul style="list-style-type: none">• Home infusion• Respiratory therapy• Visits for private duty nursing (RN, LVN)• Skilled nursing visits as defined for home health purposes (may include RN or LVN).• Home health aide when included as part of a plan of care during a period that skilled visits have been approved.• Speech, physical, and occupational therapies.	<ul style="list-style-type: none">• Requires prior authorization and physician prescription.• Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker.• Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.• Services are not intended to replace 24-hour inpatient or skilled nursing facility services.	None
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state operated facilities, including but not limited to: <ul style="list-style-type: none">• Neuropsychological and psychological testing.	<ul style="list-style-type: none">• Requires prior authorization for non-emergency services.• Does not require primary care physician referral.• When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Applicable level of inpatient copay applies.

Covered Benefit**Limitations****Copayments**

Outpatient Mental Health Services

Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to:

- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
- Medication management.
- Neuropsychological and psychological testing.
- Rehabilitative day treatments.
- Residential treatment services.
- Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment).
- Skills training (psycho-educational skill development).

- May require prior authorization.
- Does not require primary care physician referral.
- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A Qualified Mental Health Provider-Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

Applicable level of copay applies.

Inpatient Substance Abuse Treatment Services

Inpatient substance abuse treatment services include, but are not limited to:

- Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.

- Requires prior authorization for non-emergency services.
- Does not require primary care provider referral.

Applicable level of inpatient copay applies.

Outpatient Substance Abuse Treatment Services

Outpatient substance abuse treatment services include, but are not limited to, the following:

- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders.
- Intensive outpatient services.
- Partial hospitalization.
- Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day.
- Outpatient treatment service is defined as consisting of at least 1 to 2 hours per week providing structured group and individual therapy, educational services, and life skills training.

- May require prior authorization.
- Does not require primary care physician referral.

Applicable level of copay applies.



Covered Benefit	Limitations	Copayments
<p>Rehabilitation Services</p> <ul style="list-style-type: none"> • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: <ul style="list-style-type: none"> • Physical, occupational, and speech therapy • Developmental assessment 	<ul style="list-style-type: none"> • Requires prior authorization and physician prescription. 	None.
<p>Hospice Care Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have 6 months or less to live, to keep patients comfortable during the last weeks and months before death. • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 	<ul style="list-style-type: none"> • Requires authorization and physician prescription. • Services apply to the hospice diagnosis. • Up to a maximum of 120 days with a 6 month life expectancy. • Patients electing hospice services may cancel this election at anytime. 	None.
<p>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</p> <p>Health Plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts 		Applicable level of copay applies for non-emergency ER.

Covered Benefit	Limitations	Copayments
<p>Transplants</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses. 	<ul style="list-style-type: none"> Requires prior authorization. 	None.
<p>Vision Benefit</p> <p>Covered services include:</p> <ul style="list-style-type: none"> One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period. 	<ul style="list-style-type: none"> Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	Applicable level of copay applies for office visit.
<p>Chiropractic Services</p> <p>Covered services do not require physician prescription and are limited to spinal subluxation.</p>	<ul style="list-style-type: none"> Does not require authorization for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). Requires authorization for additional visits. 	Applicable level of copay applies for office visit.
<p>Tobacco Cessation Program</p> <p>Covered up to \$100 for a 12-month period limit for a plan-approved program.</p>	<ul style="list-style-type: none"> May require authorization. Health Plan defines plan-approved program. May be subject to formulary requirements. 	None.

CHIP Member Prescriptions

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

Family Planning Services

Family planning services are not covered for CHIP members.

CHIP Emergency Dental Services

Texas Children’s Health Plan is responsible for emergency dental services provided to CHIP members and CHIP Perinate Newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

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

CHIP Non-emergency Dental Services:

Texas Children’s Health Plan is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through Dental Managed Care Organizations.

Texas Children’s Health Plan is **responsible** for paying for treatment and devices for craniofacial anomalies.

Exclusions

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by the Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Acupuncture services, naturopathy, and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet, and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the member or the vendor .
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a physician.
- Donor non-medical expenses.

- Charges incurred as a donor of an organ when the recipient is not covered under this Health Plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

Medical Necessity

Covered services for CHIP members must meet the CHIP definition of “medically necessary.”

Medically necessary means:

- Health care services that are:
 - Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life.
 - Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions.
 - Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies.
 - Consistent with the diagnoses of the conditions.
 - No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
 - Not experimental or investigative.
 - Not primarily for the convenience of the member or provider.
- Behavioral health services that are:
 - Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder.
 - In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
 - Furnished in the most appropriate and least restrictive setting in which services can be safely provided.
 - The most appropriate level or supply of service that can safely be provided.
 - Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered.
 - Not experimental or investigative.
 - Not primarily for the convenience of the member or provider.

Emergency Services

Emergency care is a covered CHIP service. Emergency services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition including post-stabilization care services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that would a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient’s health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Copayments for Certain Medical Services

A copayment is when a member has to pay a part of their bill each time they get certain health care services. The following table lists the CHIP copayment schedule according to family income. Copayments for medical services or prescription drugs are paid to the health care provider at the time of service.

No copayments are paid for preventive care, such as immunizations, well child, or well baby visits. The member's Health Plan ID card lists the copayments that apply to him or her. Members should present their ID card whenever they receive health care services.

Effective March 1, 2012.

Federal Poverty Levels	Office Visits	Cost per emergency room visit	Inpatient hospital care	Prescriptions generic drugs	Prescriptions brand drugs	Reporting caps per enrollment period
Native Americans (CHNA)	\$0	\$0	\$0	\$0	\$0	\$0
At or below 100% (CHIP)	\$3	\$3	\$15	\$0	\$3	5% cap of family annual net income
101%-150% (CHIP 1)	\$5	\$5	\$35	\$0	\$5	5% cap of family annual net income
151%-185% (CHIP 2)	\$20	\$75	\$75	\$10	\$35	5% cap of family annual net income
186%-200% (CHIP 3)	\$25	\$75	\$125	\$10	\$35	5% cap of family annual net income

CHIP Value Added Services

	Value Added Service	Description	Harris	Jefferson
Extra Help for Pregnant Women	Pregnancy Essentials Kit & Canvas Tote	<ul style="list-style-type: none"> • Canvas Tote with prenatal essentials for Mom-to-be for 1st trimester • Within 42 days of enrollment 	◆	◆
	Infant Care / Safe Sleep Class	<ul style="list-style-type: none"> • Infant care • Development • Sleep habits <ul style="list-style-type: none"> • SIDs • Gift of a book upon completion 	◆	
	Car Seat Safety Class	<ul style="list-style-type: none"> • Reading safety labels • Installation <ul style="list-style-type: none"> • Appropriate sizing 	◆	
	Childbirth Education Class	<ul style="list-style-type: none"> • Nutrition • Comfort positions • Lamaze Certified Childbirth Educator <ul style="list-style-type: none"> • Childbirth choices • The importance of skin-to-skin contact 	◆	
	Breastfeeding Basics and Beyond Class	<ul style="list-style-type: none"> • Benefits of breastfeeding for both mom and baby 	◆	
	Becoming a Mom Educational Class	<ul style="list-style-type: none"> • Stages of pregnancy and post-delivery • What moms can expect throughout each trimester 	◆	
	Infant CPR Training Class	<ul style="list-style-type: none"> • Non-certified <ul style="list-style-type: none"> • How to respond if your baby is choking 	◆	
	Portable Crib/Playpen	<ul style="list-style-type: none"> • After first postpartum visit 21-56 days after delivery 	◆	◆
Health and Wellness	Asthma Education Gift Card	<ul style="list-style-type: none"> • \$50 Gift Card (Walmart), upon completion of • Series of 6 Asthma Education Classes 	◆	
	Post Hospitalization Follow-up Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of • Post hospitalization visit within 14 days of discharge • Up to 3 times per member 		
	Diabetes Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), up to 3 cards upon completion of each • Annual diabetic eye exam OR • Biannual HbA1c Blood test (every 6 months) OR • Maintain an under 8 HbA1c blood result every 6 months 	◆	◆
	Cervical Cancer Screening Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of screening • Ages 21-64 		
	Smoking Cessation Benefit	<ul style="list-style-type: none"> • Up to \$75 per month for stop-smoking products for tobacco dependent parents of members who agree to coaching 	◆	◆
	24 Hour Nurse Help Line	<ul style="list-style-type: none"> • Nurse staffed phone service line available to member 24 hours a day/ 7 days a week 	◆	◆
Extra Help for Families	Dental Health Services	<ul style="list-style-type: none"> • Comprehensive Oral Exam • 2 routine exams per 12 months • Emergency exams • Ages 21 and up <ul style="list-style-type: none"> • X-rays • Fillings • Routine extractions • 2 cleanings per 12 months 		
	Diapers	<ul style="list-style-type: none"> • Up to 2 free packs of disposable diapers, upon completion of • Wellchild check at the 12- and 15-month intervals (5th & 6th THSteps) 	◆	◆
	Caregiver Respite Care Services	<ul style="list-style-type: none"> • In-home respite services to relieve unpaid primary caregivers • Limited to 8 hours per year 		
	Extra Help Getting A Ride	<ul style="list-style-type: none"> • TCHP will arrange for transportation through vendor OR • TCHP will offer prepaid Gas Card 	◆	◆
	Parent Training Class	<ul style="list-style-type: none"> • TCHP educators will offer parent training seminars on a variety of topics 		
Stay Active!	TCHP Keep Fit Program	<ul style="list-style-type: none"> • Healthy eating material • At home work-out materials • Quarterly newsletter • Assigned health coach <ul style="list-style-type: none"> • Health / fitness sessions • 10 week Weight Watcher program • Ages 10–18 with BMI of 20+ 	◆	◆
	Soccer Clinics, a partnership with the Houston Dynamo	<ul style="list-style-type: none"> • Participation in a soccer clinic • Two tickets to Dynamo game at BBVA Compass Stadium <ul style="list-style-type: none"> • Ages 7-12 	◆	
	Sports Team Fee Assistance	<ul style="list-style-type: none"> • Enrollment and access to any sports/physical activity program available for the member • Up to \$100/year per member 		
	Sports / School Physical	<ul style="list-style-type: none"> • 1 Annual <ul style="list-style-type: none"> • Ages 15-19 	◆	◆
Family Fun	Water Park Day	<ul style="list-style-type: none"> • Access to a local waterpark for the member and their family 	◆	◆
	Movie Day	<ul style="list-style-type: none"> • A private movie screening of new release at the theater with concessions for the members 	◆	◆
	Sensory-Friendly Movie Days	<ul style="list-style-type: none"> • Brighter lighting • Lower sound <ul style="list-style-type: none"> • Shorter previews • Welcoming/accepting environment 		
	Boys and Girls Club of Greater Houston	<ul style="list-style-type: none"> • Free summer and school year membership 	◆	

XXVI.

Provider Responsibilities

Preventive Health Services

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

- Well child checkups following the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
- Immunizations, TB screenings, and other measures for the prevention and detection of disease, including instructions in personal health care practices and information on the appropriate use of medical resources.
- Education of members about their right to self-refer to any network OB/GYN provider for OB/GYN health-related care.

Preventive Care Guidelines

Requirements

Preventive care guidelines have been established by the Texas Children's Health Plan Medical Advisory Committee and the Quality Improvement Committee and are updated periodically to reflect current recommendations. The American Academy of Pediatrics (AAP) schedule has been modified to meet federal and state requirements in regards to the components of the visits at specific ages.

Recommendations for Preventive Pediatric Health Care

Medical checkups are covered for members from birth through 18 years of age for CHIP members, using the American Academy of Pediatrics Health Care guidelines. The medical checkup periodicity schedules specify the ages that medical screens/checkups are to be performed using the required screening protocol.

Primary Care Provider Responsibilities

HHSC encourages providers participating in the CHIP program to practice the medical home model for members with CHIP. Texas Children's Health Plan supports the medical home model to deliver accessible, comprehensive, family-based care with coordination and compassion to members. To realize the maximum benefit of health care, each family and individual needs to be a participating member of a readily identifiable, community-based medical home. The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership among the individual and family, health care providers within the medical home and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship to provide continuity of services and culturally effective care.

The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, specialty/hospital services and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

The primary care provider either furnishes or arranges for all the client's health care needs, including well checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

Availability and Accessibility

Texas Children's Health Plan members are assured timely access to services and availability of providers within the established standards, as noted below. In all cases below, "day" is defined as calendar day.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 following American Academy of Pediatrics (AAP) periodicity schedule
Newborns	In no case later than 14 days of enrollment and following American Academy of Pediatrics (AAP) periodicity schedule

24-Hour Availability

Primary care providers are required to provide 24-hour coverage, 7 days a week for Texas Children's Health Plan members. Arrangements for coverage while off-duty or on vacation are to be made with other participating providers. Texas Children's Health Plan should be notified of the provider's coverage prior to a leave of absence.

Texas Children's Health Plan's contracts with primary care providers state that primary care providers must "be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week." Additionally, primary care provider contracts state that primary care providers must maintain 1 of the following to receive calls from members after normal business hours:

- The office telephone is answered after-hours by an answering service, which meets the language requirements of the major population groups and which can contact the primary care provider or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- 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 primary care provider or another provider designated by the primary care provider. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after hours to another location where someone will answer the telephone and be able to contact the primary care provider or another designated individual medical practitioner who can return the call within 30 minutes.

Providers Terminating from Plan

Any providers who elect to terminate Texas Children's Health Plan participation must notify Texas Children's Health Plan Provider and Care Coordination by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of the contract with Texas Children's Health Plan. Texas Children's Health Plan will notify any affected current members in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the preceding month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Texas Children's Health Plan to efficiently transfer patients to another primary care provider. Physicians are requested to continue care in progress until all members can be successfully transferred to new primary care providers.

Member Education about Member's Right to Designate an OB/GYN

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

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

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

Authorization for Health Services

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

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

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

Authorizations for in-network specialists are not required.

Effective February 9, 2015. The following services require authorizations:

Medical Authorizations

- All out-of-network services
- Ambulance services (non-emergent transport)
- Augmentative Communication Devices
- Baclofen injections/pump
- Bariatric Surgery
- Botox Injections
- Chemotherapy non-FDA approved
- Circumcision greater than 1 year of age
- Cochlear Implant
- Contact lenses due to disease process
- Cosmetic Surgery
- Cranial Molding Orthosis (Helmets)
- Dental Medically necessary (except for cleft palate)
- Gait trainer
- All genetic testing

- Home Health Care
- Hospital grade Blood Pressure Monitors in home use
- Hospital Beds and accessories
- Hospital Inpatient care
- Makena Injections
- Nutritional Supplements
- Oral Surgery
- Organ Acquisition
- PET Scans
- Prescribed Pediatric Extended Care Centers
- Private Duty Nursing in home
- Prosthetics
- Skilled Nursing facility
- SPECT Scans
- Therapy – Physical, Occupational, Speech (including initial Eval)
- TMJ diagnosis and treatment

- Transplant Evaluation
- Vision Care, medically necessary
- Wheelchairs and accessories

Behavior Health Authorizations

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

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

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

Authorization of Clinician-Directed Care Coordination for Medically Complex Members

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

Definitions of medically complex and multidisciplinary care are defined by Texas Children's Health Plan as documented in the Texas Medicaid Bulletin, No. 209 p. 163.

Calls for authorization may be placed at 832-828-1004. Failure to comply with this process may result in nonpayment of claims. If you need further assistance or clarification, please contact your provider relations manager or call the Provider Relations telephone line at 832-828-1008.

Members' Right To Choose a Texas Children's Health Plan Network Pharmacy

Texas Children's Health Plan allows a member to select and have access to any pharmacy in the Navitus network. Texas Children's Health Plan has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the CHIP program. For questions related to pharmacy, members should contact Texas Children's Health Plan Member Services at 1-866-959-2555.

Member Education about Member's Right to Eye Health Care Services

Texas Children's Health Plan allows a member to select and have access to, without a primary care provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery.

Referral to Network Facilities and Providers

Authorizations for referrals to in-network specialists are not required. It is recommended that a primary care provider check with Texas Children's Health Plan Member Services to confirm specialist network status. Texas Children's Health Plan does not need a copy of the referral form.

The primary care provider is expected to refer Texas Children's Health Plan members to Texas Children's Health Plan providers, as needed, for behavioral health services. If a primary care provider is unsure that their patient requires behavioral health services, the primary care provider is encouraged to refer the patient to a behavioral health specialist to make that assessment by calling 832-828-1004. Texas Children's Health Plan members may self-refer to behavioral health providers for treatment. The behavioral health provider must attempt to obtain a release of information from the Texas Children's Health Plan member to allow the behavioral health provider and primary care provider to share this information.

To authorize services, please call 832-828-1004 or fax to 832-825-8760. Contact a Provider Relations Manager to get more information.

Members' Right to a Second Opinion

Texas Children's Health Plan members may access a second opinion regarding any health care service.

A member must be allowed access to a second opinion from a network provider or out-of-network provider, if a network provider is not available, at no additional cost to the member.

Specialty Care Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Texas Children's Health Plan members who have been referred by their primary care provider for specified consultation, diagnosis, and/or treatment. The specialist must communicate with the primary care provider regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the primary care provider. The specialist should also respond to requests from the Texas Children's Health Plan Utilization Management Program for pertinent clinical information that assists in providing a timely authorization for treatment.

To obtain prior authorization for required services, please call 832-828-1004 or fax to 832-825-8760.

Provider will maintain such offices, equipment, patient services personnel, and allied health personnel as may be necessary to provide contracted services.

If the provider is a specialty care physician, the provider will ensure that contracted services are provided under this agreement at the specialty care physician's office during normal business hours, and be available to beneficiaries by telephone 24 hours a day, 7 days a week for consultation on medical concerns.

Responsibility to Verify Member Eligibility Related to Treatment Authorizations

It is the responsibility of the treating provider to verify that the patient continues to be a Texas Children's Health Plan and a CHIP-eligible member for services during the treatment period. Verification of eligibility may be made by:

- Calling the CHIP Provider Eligibility Hotline—CHIP providers can receive eligibility information by calling the CHIP Provider Eligibility Hotline Monday through Friday 8 a.m. to 5 p.m. (Central Time). The hotline number is 1-800-647-6558. Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently enrolled CHIP member.
- Calling Texas Children's Health Plan Member Services at 832-828-1004.
- Calling Telephone TouCHPoint at 832-828-1007.
- Visiting Provider TouCHPoint at www.TexasChildrensHealthPlan.org/Providers.

Continuity of Care

- Pregnant women information—Texas Children’s Health Plan will take special care not to disrupt care in progress for newly enrolled members. Pregnant members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN provider (even if the provider is out-of-network) through the member’s postpartum checkup. A member may change her OB/GYN if she requests.
- Member moves out of service area—Texas Children’s Health Plan requests that members tell us in writing if they move, change their address or phone number, even if these changes are temporary. If members move out of the service area, they may no longer be eligible. Our CHIP service area includes Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton counties. Texas Children’s Health Plan will provide or pay out-of-network providers who provide medically necessary covered services to members who move out of the service area through the end of the period for which capitation has been paid for the member.
- 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 CHIP member.

Justification Regarding Out-of-Network Referrals—Including Partners Not Contracted with Texas Children’s Health Plan

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-plan specialty referrals are needed. Again, specialty referrals include services which cannot be provided within the Texas Children’s Health Plan network. The primary care provider submits authorization form by calling 832-828-1004 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.

Options for Member Non-Compliance

Contact Texas Children’s Health Plan Provider and Care Coordination in the event that a member is non-compliant, becomes abusive to you or your staff, and/or continues to demand services that, in your professional judgment, are not medically necessary.

The problem will be researched and resolved. The primary care provider may request, in writing, to Texas Children’s Health Plan that a member be transferred to another primary care provider for the following reasons:

- Member is disruptive, unruly, threatening, or uncooperative to the extent that the member’s membership seriously impairs the provider’s ability to provide services to the member, provided the behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition.
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary and the member has received full informed consent regarding the prescribed treatment course.

Remember, physicians are not allowed to withhold or discriminate in any way in the treatment of a member or to transfer a member from his/her practice because of the health condition of a member or the amount of services provided. A primary care provider cannot transfer a member to another primary care provider without the prior written authorization of the Texas Children’s Health Plan Medical Director. Texas Children’s Health Plan requests that the physician continue care until Texas Children’s Health Plan can successfully transfer the member to a new primary care provider’s care.

Primary care providers will not refuse to accept a member as a patient on the basis of health status, previous use of services, or the medical condition of the member.

Community First Choice

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the Member’s service plan.
- The program provider must have current documentation which includes the member’s service plan, 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)

- The HCS or TxHmL program provider must 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.).
- The program provider must 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.
- The program provider must 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).
- The program provider must 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.
- The program provider must 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.
- The program provider must 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.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- 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.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must 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.
- The program provider must 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.

Reporting Changes to the Health Plan

Providers have a minimum of 30 calendar days to inform Texas Children's Health Plan of any changes to the provider data listed below. Changes not received in writing are not valid. If Texas Children's Health Plan is not informed within the timeframe, Texas Children's Health Plan and its designated claims administrator are not responsible for the potential claims processing and payment errors.

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

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

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

Hours of operation that practitioners offer to Medicaid members should be no less than those offered to commercial members. Please contact your Provider Relations Manager with reported changes.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary or not part of a covered preventive family planning service if both the following conditions are met:

- A specific service or item is provided at the member's request
- The provider has obtained and kept a written Member Acknowledgement Statement signed by the client that states:
"I understand that, in the opinion of (Provider's name) the services or items that I have requested to be provided to me on (dates of service) may not be covered under the CHIP Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary."
"Comprendo que, según la opinión del (nombre del Proveedor), es posible que CHIP no cubra los servicios o las provisiones que solicité (fecha de servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el HHSC o su agente de seguros de salud determinan la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

A provider may bill the following to a member without obtaining a signed Member Acknowledgement Statement:

- Any service that is not a benefit of the CHIP program or Texas Children's Health Plan's benefit package (for example, personal care items).
- All services incurred on non-covered days due to lack of eligibility.
- The provider accepts the member as a private-pay patient.

Private Pay Form Agreement

Providers must advise members that they are accepted as private pay patients at the time the service is provided and that they will be responsible for paying for all services received. The member must sign written notification.

The member is accepted as a private-pay patient pending CHIP eligibility determination and does NOT become eligible for CHIP retroactively. The provider is allowed to bill the patient as a private-pay. If the member becomes eligible retroactively, the member should notify the provider of the change in status. Ultimately, the provider is responsible for filing timely CHIP claims. If the patient becomes eligible, the provider MUST refund any money paid by the patient and file CHIP claims for all services rendered.

PRIVATE PAY AGREEMENT

I, _____ understand that the provider _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any service I receive.

The provider will not file a claim to CHIP for services provided to me.

Signed: _____

Dated: _____

PACTO DE PAGO PRIVADO

Yo, _____ entiendo que el proveedor _____ me esta aceptando como paciente de pago privado por el periodo de _____, y me hago responsable en pagar por cualquier servicio rendido.

El proveedor no le mandara a CHIP ningún reclamo por servicios que me rinda.

Nombre: _____

Fecha: _____

Routine, Urgent, and Emergent Services

Definitions

Emergent/Emergency

Emergency services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or and emergency behavioral health condition, including post-stabilization care services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- Requires immediate intervention and/or medical attention without which members would present an immediate danger to themselves or others.
- Which renders members incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency departments are authorized by Texas Children's Health Plan to provide medically necessary and appropriate treatment for any Texas Children's Health Plan member. If a Texas Children's Health Plan member needs to be admitted, the hospital must notify the Texas Children's Health Plan Utilization Management Program within 24 hours of the admission or the next business day, by either calling 832-828-1004 or by faxing the encounter record to 832-825-8760. The primary care provider should also be notified by the hospital about the admission within 24 hours or the next business day.

Urgent

Urgent condition means a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the member's primary care provider or primary care provider designee to prevent serious deterioration of the member's condition or health.

Routine

Routine or preventive (non-emergent) is when postponement of treatment will not endanger life, limb, or mental faculties of patient. That is, a patient's condition permits adequate time to schedule necessary history and physical, laboratory, radiology, or other diagnostic studies on an outpatient basis.

Texas Children's Health Plan is committed to ensuring that members receive a timely and appropriate level of access to all levels of care—emergent, urgent, routine, and preventive. Medical home and specialty providers are expected to deliver care within the following timeframes.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 following American Academy of Pediatrics (AAP) periodicity schedule
Newborns	In no case later than 14 days of enrollment and following American Academy of Pediatrics (AAP) periodicity schedule

Emergency Prescription Supply

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

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

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

To be reimbursed for a 72-hour emergency supply please see instructions on page 95.

Emergency Transportation—Ambulance

Ambulance transport is an emergency service when the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could result in serious impairment, dysfunction, or failure of 1 or more organs or body parts and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

Non-emergency Transportation—Medical Transportation

When a Texas Children's Health Plan member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is a non-emergency service. Non-emergency transports for a Texas Children's Health Plan member with severe disabilities must be to or from a scheduled medical appointment.

A round-trip transfer from the member's home to an outpatient or freestanding dialysis or radiation facility is covered only when the member meets the definition of severely disabled. Severely disabled means that the member's physical condition limits his/her mobility and requires the member to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems, including oxygen or IV infusion. A run sheet or other supporting documentation is required for non-emergency transportation and must clearly state the member's physical condition and severity at the time of the transfer. The run sheet must include the signature of the EMT transporting the client. Non-emergency transfers of members whose condition does not meet the severely-disabled criteria are not covered benefits.



CHIP Provider Complaints and Appeals

Provider Complaints Process to MCO

As a CHIP Health Plan, it is the policy of Texas Children's Health Plan to adhere to Texas Department of Insurance (TDI) Provider Guidelines. A 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 may file a complaint or appeal with Texas Children's Health Plan. The following information will assist providers in filing.

Complaint Issues

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

Texas Children's Health Plan
Attention: Provider and Care Coordination
PO Box 301011 NB 8301
Houston, TX 77230-1011

Texas Children's Health Plan will acknowledge in writing your written complaint within 5 business days and respond to your complaint within 30 days of receipt of the complaint.

Provider Appeal of Claim Determinations

Medical Necessity Appeals/Appeals to a Denial for Service Authorization

If Texas Children's Health Plan denies a provider's request for service authorization due to medical necessity, a provider has 60 calendar days to request an appeal. To request an appeal, please send your written request to:

Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709 WLS 8390
Houston, TX 77230

To assist Texas Children's Health Plan in your request, please state the reason you are requesting your appeal and submit supporting medical documentation. Texas Children's Health Plan will acknowledge in writing your request within 5 business days, and if necessary, request specific medical information to support your appeal. If you do not provide Texas Children's Health Plan with the requested medical information within 10 days, Texas Children's Health Plan will make its decision based on the information provided.

Texas Children's Health Plan will respond to your appeal within 30 calendar days of receipt of the appeal.

All appeals of adverse determination for which medical records are not received within 30 calendar days of the filing date will be finalized and the original decision will be upheld. This decision is final and binding, and the provider will have exhausted his or her appeal rights with Texas Children's Health Plan.

Texas Children's Health Plan will allow Community-based Long Term Services and Support providers to appeal claims that have not paid or denied by the 31st day following receipt.

Expedited Appeals to a Denial for Service Authorization

If Texas Children's Health Plan denies a request for services and a member's medical condition may be jeopardized by the standard 30 calendar day appeal timeframe, a provider may request an expedited appeal review. To request an expedited review, please fax the request to 832-825-8796. Texas Children's Health Plan will respond to expedited appeals involving emergency services or continued hospitalization within 1 business day.

How to Submit Appeals via Provider Portal

For Appeals: Submission of appeals for STAR Kids is available via the Texas Children's Health Plan portal.

Please contact Texas Children's Health Plan Provider Relations department 1-800-731-8527.

Second Level Appeals to a Denial for Service Authorization

If Texas Children's Health Plan upholds its decision to deny authorization for requested services due to medical necessity, you have a right to request a second review from a different provider in the same or similar specialty. You must file your request within 30 calendar days from receipt of Texas Children's Health Plan appeal decision and set forth in writing good cause for having a particular specialty review.

To request a specialty review, please send your request to:

Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709 WLS 8390
Houston, TX 77230

Texas Children's Health Plan will complete its specialty review within 15 business days from receipt of your request.

Provider Complaint/Appeal Process to Texas Department of Insurance

A provider has the right to file an appeal with the TDI. Provider complaints or appeals to TDI should be sent to the following:

Texas Department of Insurance
PO Box 149097
Austin TX 78714-9091
512-463-6500 or 1-800-252-3439
Fax 512-475-1771
www.tdi.state.tx.us



CHIP Member Complaint and Appeal Process

Member Complaint Process

If a Texas Children's Health Plan member expresses a desire to file a complaint, providers should direct him or her immediately to Texas Children's Health Plan. Complaints can be filed by calling or writing Member Services:

Texas Children's Health Plan
Attention: Member Services
PO Box 301011, NB 8360
Houston, TX 77230-1011
832-828-1002 or toll-free at 1-866-959-6555

Member advocates are available to give members assistance with filing their complaint and understanding the complaint process.

Within 5 business days of receiving a complaint, Texas Children's Health Plan will send the member a letter to confirm the day we received the complaint. If the complaint was filed by calling us, the letter will include a form for the member to complete describing his or her complaint. The member or their authorized representative will need to complete this form and return it for a prompt resolution. The member can also call Member Services at 832-828-1002 or toll-free at 1-866-959-6555 if they need assistance completing the form.

Texas Children's Health Plan responds to complaints in writing within 30 calendar days. A resolution letter will be mailed to the member. The letter will include what we have done to address their complaint.

If a complaint involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan will respond based on the immediacy of the case, but not to exceed 1 business day.

If a member is not satisfied with Texas Children's Health Plan's decision on a complaint, the member has the right to appeal, in writing, within 30 days of when he or she gets our complaint response. The appeal will be reviewed by a Complaint Appeal Panel.

When Texas Children's Health Plan receives a written appeal or request for a Complaint Appeal Panel, it will send a written acknowledgment letter to the complainant within 5 business days. Within 5 business days from the date the Complaint Appeal Panel meets, Texas Children's Health Plan will send to the complainant all information it will review regarding the complaint and the names and physician specialty, (if applicable), of the Complaint Appeal Panel. The complainant may appear in person at the Complaint Appeal Panel and present expert testimony supporting his or her position.

Texas Children's Health Plan will complete the appeal process and respond to the complainant's appeal within 30 calendar days from receipt; however, if the complaint appeal involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan will respond based on the immediacy of the case, but not to exceed 1 business day.

In lieu of a Complaint Appeal Panel, Texas Children's Health Plan may request a review by a different physician or provider of same or similar specialty who typically manages same type of medical condition.

Member Standard Appeal Process

A member has the right to appeal any services that have been denied by Texas Children's Health Plan because it does not meet the criteria of medical necessity. A denial of this type is called an "adverse determination."

Texas Children's Health Plan will notify the provider and member when it issues an adverse determination in accordance with the following timeframes: within 1 business day by telephone or electronic transmission to the provider, if hospitalized at time of adverse determination, followed by letter to the member within 3 business days, or 3 business days to the provider and member if not hospitalized.

If Texas Children's Health Plan is denying post-stabilization care following an emergency, Texas Children's Health Plan will issue the adverse determination within 1 hour of the request. To appeal an adverse determination, a member may contact Texas Children's Health Plan at the following address:

Texas Children's Health Plan
Attention: Complaint and Appeal Coordinator
Member Services Department
PO Box 301011, NB 8360
Houston, TX 77230-1011
832-828-1002 or toll-free at 1-866-959-6555

The member may contact the Texas Children's Health Plan Member Services Department at the above telephone numbers and a Texas Children's Health Plan member advocate will assist him or her in filing an appeal, if needed.

A member may file an appeal to an adverse determination within 30 calendar days of the notice of adverse determination.

A member may file an appeal verbally or in writing. When Texas Children's Health Plan receives a written appeal, it will send a written acknowledgment letter to the appellant within 5 business days. If the appeal is received verbally, Texas Children's Health Plan will send the written acknowledgment letter within 5 business days and include one-page appeal form for the appellant, or his or her designated representative, to complete and return to Texas Children's Health Plan at the above address. Texas Children's Health Plan will generally respond to appeals within 30 calendar days; however, if an appeal involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan will respond based on the immediacy of the case, but not to exceed 1 business day.

Member Expedited Appeal Process

If a member's health condition would be adversely affected by following the standard appeal process, a member or someone acting on their behalf may request an expedited appeal orally or in writing. These include cases involving denials for emergency care, denials of care for life-threatening conditions, and denials for continued hospital stay. For assistance or to request an expedited review, the member may contact Texas Children's Health Plan at the following:

Texas Children's Health Plan
Attention: Utilization Review
PO Box 301011, WLS 8360
Houston, TX 77230-1011

Texas Children's Health Plan clinical staff will evaluate the request for an expedited review and if the situation meets the above criteria, a specialist in the same or similar specialty, who was not involved in the previous decision-making, will review the case and render a decision within 1 business day. If the appeal does not meet the above criteria for an expedited review, the appeal will be handled under the standard appeal timeframes.

Member Complaint/Appeal to Texas Department of Insurance and Requesting an Independent Review

Independent Review Organization Process

Independent Review Organization is an entity that is certified by the Commissioner of Insurance under Insurance Code Article 21.58c to conduct independent review of adverse determinations. A member has a right to appeal to an independent review organization (IRO) if Texas Children's Health Plan makes a determination that treatment that is recommended, but not yet performed, is not medically necessary or appropriate. The independent review system is coordinated through TDI, who assigns the appeal request to an IRO not associated with Texas Children's Health Plan, who then performs a final administrative review to determine medical necessity and appropriateness. The IRO's decision is binding on Texas Children's Health Plan and Texas Children's Health Plan pays for the cost of the IRO.

To request an IRO review, a member must contact Texas Children's Health Plan at the following address:

Texas Children's Health Plan
Attention: Appeals Department
PO Box 301011, NB 8390
Houston, TX 77230

Texas Children's Health Plan will send the member forms to request an IRO review. Once Texas Children's Health Plan receives the forms, we will immediately forward the member's request and any clinical information to TDI for the IRO review. TDI will assign the request to an IRO within 1 business day. If any additional information is required by the IRO, Texas Children's Health Plan must provide that information within 3 business days.

The IRO must reach a decision within 15 calendar days after receiving the necessary information but no later than 20 calendar days after the IRO receives the request. In cases involving life-threatening conditions, the IRO must reach a decision within 5 calendar days after receiving the necessary information but no later than 8 calendar days after the IRO receives the request.

An IRO review is not available if:

- Texas Children's Health Plan refuses to pay for a service that the plan does not cover, such as cosmetic surgery.
- A member has already received treatment and Texas Children's Health Plan then determines that the treatment was not medically necessary or appropriate.

Complaints and appeals to the Texas Department of Insurance

A member may file a CHIP complaint or appeal directly with the TDI. To file a CHIP complaint or appeal, please send your correspondence to:

Texas Department of Insurance
Consumer Protection (111-1a)
PO Box 149091
Austin, TX 78714-9104
1-800-252-3439
Fax: 512-475-1771
www.tdi.state.tx.us

XXX.

CHIP Member Eligibility

CHIP Member Eligibility

HHSC or its administrative services contractor makes the eligibility determinations for each potential enrollee in the CHIP program. The administrative services contractor enrolls and disenrolls individuals in and out of CHIP. Texas Children's Health Plan is not allowed to induce or accept disenrollment requests from members.

HHSC makes no guarantees or representations regarding the number of eligible members who will ultimately be enrolled into Texas Children's Health Plan or the length of time any such enrolling members remains enrolled beyond the minimum mandatory enrollment periods established for each HHSC MCO program.

The administrative services contractor electronically transmits to Texas Children's Health Plan new member information and change information applicable to active members on a monthly basis.

Texas Children's Health Plan must accept all persons who choose to enroll as members in Texas Children's Health Plan or who are assigned as members by HHSC, without regard to the member's previous coverage, health status confinement in a health care facility or any other factor. CHIP members may change health plans once per enrollment year.

Term of Coverage

CHIP members have 12 continuous months of coverage per enrollment period.

Verifying Eligibility

Providers are responsible for requesting and verifying current eligibility information from the member by asking the member to produce their Texas Children's Health Plan ID Card.

Texas Children's Health Plan Identification Card

Texas Children's Health Plan issues a Texas Children's Health Plan ID Card to all its members. When a Texas Children's Health Plan member visits your office make a copy of both sides of the Texas Children's Health Plan ID Card for your records. Please note that while the Texas Children's Health Plan ID Card identifies a Texas Children's Health Plan member, it does not confirm eligibility or guarantee benefit coverage or payment.

Providers should also verify the member's current eligibility status through Texas Children's Health Plan.

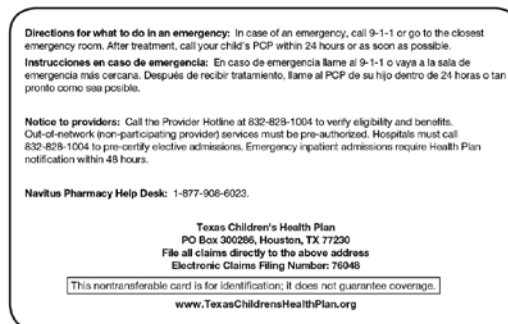
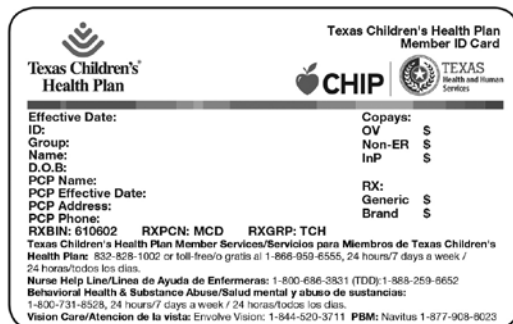
The Texas Children's Health Plan ID Card contains the following information:

Front:

- Member name
- Member ID number
- Member primary care provider
- Effective date for primary care provider
- Primary care provider's phone number

Back:

- Claims address
- Information needed to submit electronic claims



Verifying Eligibility Through Texas Children's Health Plan

Providers can verify member eligibility by contacting Texas Children's Health Plan through the internet and by telephone.

Telephone TouCHPoint

Telephone TouCHPoint, a telephone-based automated self-service application, is available 24 hours a day, 365 days a year for providers to request/receive current member eligibility information. A provider can access Telephone TouCHPoint through the provider hotline at 832-828-1004 or directly by calling 832-828-1007. Telephone TouCHPoint gives an immediate verbal response. Providers can also request the response be sent via secure e-mail. The e-mail response is sent within 2 minutes of the request.

Provider TouCHPoint Self Service Portal

Providers can also verify members' eligibility via the internet at Texas Children's Health Plan's website by using Texas Children's Health Plan's Provider TouCHPoint portal. Texas Children's Health Plan's web address is www.TexasChildrensHealthPlan.org. To access Provider TouCHPoint click on the Provider section of the website.

Call Texas Children's Health Plan's Provider and Care Coordination at 832-828-1008 to become a registered user of the portal. Provider TouCHPoint users can check member eligibility, benefits, primary care provider selection, and claims status.

Texas Children's Health Plan Member Services

Providers can call Texas Children's Health Plan Member Services Monday through Friday, 8 a.m. to 5 p.m. at 832-828-1004 to verify members' eligibility and PCP selection.



CHIP Member Rights and Responsibilities

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

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

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

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

Member Education about Member's Right to Designate an OB/GYN

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

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

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

Reporting Waste, Abuse, or Fraud in CHIP by a Provider or Client

If a member suspects a person who receives benefits or a provider (a doctor, dentist, counselor, etc.) has committed waste, abuse, or fraud, he/she has a responsibility and a right to report it.

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

Members can report directly to Texas Children's Health Plan any providers or clients they suspect of waste, abuse, or fraud:

Texas Children's Health Plan
Fraud and Abuse Investigations
PO Box 301011, NB 8302
Houston, TX 77230
832-828-1320 or toll-free at 1-866-959-6555

Do you want to report waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> and pick "I WANT TO: Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Texas Children's Health Plan
Fraud and Abuse Investigations
PO Box 301011, NB 8302
Houston, TX 77230
832-828-1320 or toll-free at 1-866-959-6555

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

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

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

When reporting about someone who gets benefits, include:

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

XXXII.

CHIP Member Enrollment and Disenrollment from Texas Children's Health Plan

Enrollment/Re-enrollment

CHIP members are required to re-enroll annually, at the end of each 12-month enrollment year.

Eligibility for enrollment/re-enrollment in CHIP is determined by the HHSC's Administrative Services Contractor. Enrollment in CHIP will begin on the first day of the month after eligibility is determined.

Pregnant Members and Infants

Providers are required to contact Texas Children's Health Plan immediately when a pregnant CHIP member is identified. The Health Plan notifies the HHSC Administrative Contractor who will in turn evaluate eligibility for Medicaid and provide appropriate resource information. Those CHIP members who are determined to be Medicaid-eligible are disenrolled from Texas Children's Health Plan's CHIP plan.

If member is not eligible for Medicaid, the Administrator will extend the member's eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the baby's birth. In the event Texas Children's Health Plan remains unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP.

Newborns are not automatically covered in CHIP. The HHSC Administrative Contractor will re-determine eligibility based on the additional member in the family. Infants that are Medicaid-eligible are not eligible for CHIP.



Disenrollment

Disenrollment may occur if a member loses CHIP eligibility. A CHIP member can lose CHIP eligibility for the following reasons:

- “Aging-out” when the member turns 19.
- Failure to re-enroll by the end of the 12-month coverage period.
- Change in health insurance status, i.e., a member enrolls in an employer-sponsored health plan.
- Death of a member.
- Member permanently moves out of the state.
- Member is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10 percent or more of the family’s gross income.
- Child’s parent or authorized representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP.
- Child’s parent or authorized representative requests, in writing, the voluntary disenrollment of a child.

Texas Children’s Health Plan can also request a member be disenrolled from Texas Children’s Health Plan—subject to approval by the HHSC—for the following reasons:

- Fraud or intentional material misrepresentation.
- Fraud in the use of services or facilities.
- Misconduct that is detrimental to safe plan operations and the delivery of services.
- Failure to establish a satisfactory patient/physician or patient/provider relationship.
- Child no longer lives or resides in the service area.

Texas Children’s Health Plan must notify the member of our decision to disenroll the member if all reasonable measures have failed to remedy the situation. If the member disagrees with the decision to disenroll the member, Texas Children’s Health Plan must notify the member of the availability of the complaint process.

Texas Children’s Health Plan cannot request a disenrollment based on adverse change in the member’s health status or utilization of services that are medically necessary for treatment of a member’s condition.

A member’s disenrollment request will require medical documentation from the primary care provider or documentation that indicated sufficiently compelling circumstances that merit disenrollment.

Providers are prohibited from taking retaliatory action against members.

Health Plan Changes

Members are allowed to make health plan changes under the following circumstances:

- for any reason within 90 days of enrollment in CHIP and once thereafter;
- for cause at any time;
- if the client moves to a different service delivery area; and
- during the annual re-enrollment period.

HHSC will make the final decision. For more information they should call CHIP toll-free at 1-800-647-6558.

CHIP Special Access Requirements

Interpreter/Translation Services

Texas Children's Health Plan provides language interpretation services to translate multiple languages. We do this through the Language Line which may be accessed by calling Member Services at 832-828-1002. Member Services will then contact the Language Line as a third party conversation.

For persons who are deaf or hearing impaired, please call Texas Relay TYY line at 1-800-735-2989 and ask them to call Member Services.

We will arrange, with 72 hours' prior notice, to have someone who speaks the member's language to meet the patient at the provider's office when they come for their appointment. For members in need of a sign language interpreter, Texas Children's Health Plan will provide an approved interpreter from the American Sign Language Association.

Trained interpreters should be used when technical, medical, or treatment information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

Provider/Care Coordination

Texas Children's Health Plan will assist the provider in coordinating the care and establishing linkages, as appropriate for our members with existing community-based entities and services, including, but not limited to:

- Maternal and child health
- Children with Special Health Care Needs (CSHCN)
- Medically Dependent Children Program (MDCP)
- Interagency Council on Early Childhood Intervention
- In home family support
- Primary home care

Texas Children's Health Plan and providers must ensure that members with disabilities or chronic or complex conditions have access to treatment by a multidisciplinary team when determined to be medically necessary for effective treatment, or to avoid separate and fragmented evaluations and service plans. The teams must include both physician and non-physician providers determined to be necessary by the member's primary care provider for the comprehensive treatment of the member. They must:

- Participate in hospital discharge planning.
- Participate in pre-admissions hospital planning for non-emergency hospitalizations.
- Develop specialty care and support service recommendations to be incorporated into the primary care provider's plan of care.
- Provide information to the member and the member's family concerning the specialty care recommendations.

Health Literacy

An estimated 40-44 million Americans are functionally illiterate and another 50 million are only marginally literate. Nearly half of the functionally literate live in poverty and one-fourth are reported to have physical, mental or health conditions that prevent them from participating fully in work, school, or housework. Texas Children's Health Plan expects that many of our members have limited ability to understand instructions and read medication bottles. Yet, most people with literacy problems are ashamed and will try to hide this from providers.

Low literacy can mean that your patient may not be able to comply with your medical advice and prescriptions because they do not understand your instructions. Patient materials should be written at a fourth- to sixth-grade reading level. The guidelines provided in this section for communication with interpreters are also good guidelines for communicating with members with limited literacy, especially asking the member to repeat your instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines. Above all else, be sensitive to the embarrassment the member may feel about limited literacy.

CHIP Perinatal



XXXIV.

CHIP Perinatal Objectives

Texas Children's Health Plan participates in CHIP Perinatal effective March 1, 2012. CHIP Perinatal is designed for pregnant women who are under 200% of the FPL and cannot qualify for Medicaid due to income or resident status. This program was authorized by Senate Bill 1, 79th Legislature, Regular Session, 2005, rider 70 to expend funds to provide unborn children health benefit coverage under CHIP. The objectives of the program include:

- Extending CHIP services to unborn children of non-Medicaid eligible women and enroll the unborn child in CHIP as soon as possible.
- Expedite enrollment to improve prenatal care and pregnancy outcomes.

XXXV.

How CHIP Perinatal Works

The expectant mother will enroll by completing an application or by calling 2-1-1 for assistance. If the mother is determined eligible, the 12 months of continuous coverage will begin based on her effective date. Coverage for the expectant mother is limited to prenatal care benefits including up to 20 prenatal visits, physician services, laboratory and radiological services, and prescription drugs. For mothers below 185% of FPL, hospital/facility charges related to labor with delivery will be covered by Texas Emergency Medicaid. Texas Children's Health Plan will be responsible for professional fees only. For mothers between 186-200% of FPL, hospital/facility charges related to labor with delivery and professional fees will be paid by Texas Children's Health Plan. All payments are subject to Texas Children's Health Plan's utilization review requirements and contract requirements.

Upon birth, the child receives full CHIP benefits for the remainder of the 12 month eligibility period. The child receives a primary care provider to provide all primary care services and to arrange for and coordinate referrals for all medically necessary specialty services. The child now receives all the same benefits as outlined in the Children's Health Insurance Program (CHIP). Please refer to the CHIP section of this manual for more information about CHIP benefits.

Texas Children's Health Plan offers value added services for CHIP Perinatal members. Enrollees in CHIP Perinatal are exempt from all enrollment fees, waiting periods, and cost sharing.



CHIP Perinatal Covered Services

Covered CHIP Perinatal services must meet the definition of Medically Necessary Covered Services as defined by the Health and Human Services Commission. There is no lifetime maximum of benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal members. CHIP Perinatal members are eligible for 12 months continuous coverage following enrollment in the program. There is no spell of illness limitation for CHIP Perinate Newborns.

Covered Benefit	CHIP Members and Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care. • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. • Surgical implants 	<p>For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.</p> <p>For CHIP Perinates in families with incomes above 185% to 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) <p>Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</p> <ul style="list-style-type: none"> • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples.



Covered Benefit	CHIP Members and Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	<ul style="list-style-type: none"> • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12 month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - cleft lip and/or palate; or - severe traumatic, skeletal, and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment. 	
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility 	<p>Not a covered benefit.</p>
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center	<p>Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products 	<p>Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:

Covered Benefit

CHIP Members and Perinate Newborn Members

CHIP Perinate Members (Unborn Child)

- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
 - dilation and curettage (D&C) procedures;
 - appropriate provider-administered medications;
 - ultrasounds; and
 - histological examination of tissue samples.
- Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.
- Surgical implants
- Other artificial aids including surgical implants
- Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
 - all stages of reconstruction on the affected breast;
 - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
 - surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - cleft lip and/or palate; or
 - severe traumatic, skeletal, and/or congenital craniofacial deviations; or
 - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment.

- dilation and curettage (D&C) procedures;
 - appropriate provider-administered medications;
 - ultrasounds; and
 - histological examination of tissue samples.
- (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.
 - (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy.
 - (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.
 - (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
 - (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic

Covered Benefit**CHIP Members and Perinate Newborn Members****CHIP Perinate Members (Unborn Child)****Physician/Physician Extender Professional Services**

Services include, but are not limited to the following:

- American Academy of Pediatrics recommended well child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations)
- Physician office visits, inpatient and outpatient services
- Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation
- Medications, biologicals, and materials administered in physician's office
- Allergy testing, serum, and injections
- Professional component (in/outpatient) of surgical services, including:
 - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
 - Administration of anesthesia by physician (other than surgeon) or CRNA
 - Second surgical opinions
 - Same-day surgery performed in a hospital without an overnight stay
 - Invasive diagnostic procedures such as endoscopic examinations
- Hospital-based physician services (including physician-performed technical and interpretive components)
- Physician and professional services for a mastectomy and breast reconstruction include:
 - all stages of reconstruction on the affected breast;
 - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
 - surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:
 - dilation and curettage (D&C) procedures;
 - appropriate provider-administered medications;

pregnancy, or a fetus that expired in utero) are a covered benefit.

- Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth.
- Physician office visits, inpatient and outpatient services
- Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation
- Medically necessary medications, biologicals, and materials administered in physician's office
- Professional component (in/outpatient) of surgical services, including:
 - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.
 - Administration of anesthesia by physician (other than surgeon) or CRNA
 - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.
 - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)
- Hospital-based physician services (including physician-performed technical and interpretive components)
- Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation.
- Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.
- Professional component associated with (a) miscarriage or (b) a non-



Covered Benefit

CHIP Members and Perinate Newborn Members

CHIP Perinate Members (Unborn Child)

- ultrasounds; and
- histological examination of tissue samples.
- Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - cleft lip and/or palate; or
 - severe traumatic, skeletal, and/or congenital craniofacial deviations; or
 - severe facial asymmetry secondary to skeletal defects, congenital conditions, and/or tumor growth or its treatment.

viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to:

- dilation and curettage (D&C) procedures;
- appropriate provider-administered medications;
- ultrasounds; and
- histological examination of tissue samples.

Prenatal Care and Pre-Pregnancy Family Services and Supplies

Not a covered benefit.

Services are limited to an initial visit and subsequent prenatal (ante partum)care visits that include:

- (1) One visit every 4 weeks for the first 28 weeks of pregnancy;
- (2) One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy; and
- (3) One visit per week from 36 weeks to delivery.

More frequent visits are allowed as medically necessary, Benefits are limited to:

Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Visits after the initial visit must include:

- Interim history (problems, marital status, fetal status);
- Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and
- Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-26 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of

Covered Benefit**CHIP Members and Perinate Newborn Members****CHIP Perinate Members (Unborn Child)**

		pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies	<p>\$20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).</p> <p>Services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:</p> <ul style="list-style-type: none"> • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. 	Not a covered benefit.
Home and Community Health Services	<p>Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN or LVN). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical, and occupational therapies. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services. 	Not a covered benefit.

Covered Benefit**CHIP Members and Perinate
Newborn Members****CHIP Perinate Members
(Unborn Child)****Inpatient Mental Health Services**

Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state operated facilities, including but not limited to:

- Neuropsychological and psychological testing.
- When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- Does not require primary care physician referral.

Not a covered benefit.

Outpatient Mental Health Services

Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to:

- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
- Neuropsychological and psychological testing.
- Medication management.
- Rehabilitative day treatments.
- Residential treatment services.
- Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) Skills training (psycho-educational skill development)
- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A Qualified Mental Health Provider-Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.
- Does not require primary care physician referral.

Not a covered benefit.

Covered Benefit	CHIP Members and Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
Inpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. • Does not require primary care provider referral. 	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders. • Intensive outpatient services. • Partial hospitalization. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least 1 to 2 hours per week providing structured group and individual therapy, educational services, and life skills training. • Does not require primary care physician referral. 	Not a covered benefit.
Rehabilitation Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational, and speech therapy • Developmental assessment. 	Not a covered benefit.
Hospice Care Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have 6 months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. • Requires authorization and physician prescription. • Services apply to the hospice diagnosis. 	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<p>Health Plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination 	<p>Health Plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth.</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person definition of emergency health condition

Covered Benefit	CHIP Members and Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	<ul style="list-style-type: none"> • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts 	<ul style="list-style-type: none"> • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. • Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. <p>Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit/</p>
Transplants	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses. 	Not a covered benefit.
Vision Benefit	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <p>Services include:</p> <ul style="list-style-type: none"> • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period 	Not a covered benefit.
Vision Benefit	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <p>Services include:</p> <ul style="list-style-type: none"> • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period 	Not a covered benefit.
Chiropractic Services	<p>Covered services do not require physician prescription and are limited to spinal subluxation.</p>	Not a covered benefit.
Tobacco Cessation Program	<p>Covered up to \$100 for a 12-month period limit for a plan-approved program</p> <ul style="list-style-type: none"> • Health Plan defines plan-approved program. • May be subject to formulary requirements. 	Not a covered benefit.
Case Management and Care Coordination Services	<p>These services include outreach informing, case management, care coordination, and community referral.</p>	Covered benefit.

CHIP Exclusions from Covered Services

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical, or other health-care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a physician/primary care provider.

- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this Health Plan.

Exclusions from Covered Services for CHIP Perinates

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

- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco cessation programs.
- Chiropractic services.
- Medical transportation not directly related to labor or threatened labor, miscarriage, or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical, or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.

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



CHIP Perinatal Value Added Services

	Value Added Service	Description	Harris Jefferson	
Extra Help for Pregnant Women	Pregnancy Essentials Kit & Canvas Tote	<ul style="list-style-type: none"> • Canvas Tote with prenatal essentials for Mom-to-be for 1st trimester • Within 42 days of enrollment 	◆	◆
	Infant Care / Safe Sleep Class	<ul style="list-style-type: none"> • Infant care • Development • Sleep habits <ul style="list-style-type: none"> • SIDs • Gift of a book upon completion 	◆	
	Car Seat Safety Class	<ul style="list-style-type: none"> • Reading safety labels • Installation <ul style="list-style-type: none"> • Appropriate sizing 	◆	
	Childbirth Education Class	<ul style="list-style-type: none"> • Nutrition • Comfort positions • Lamaze Certified Childbirth Educator <ul style="list-style-type: none"> • Childbirth choices • The importance of skin-to-skin contact 	◆	
	Breastfeeding Basics and Beyond Class	<ul style="list-style-type: none"> • Benefits of breastfeeding for both mom and baby 	◆	
	Becoming a Mom Educational Class	<ul style="list-style-type: none"> • Stages of pregnancy and post-delivery • What moms can expect throughout each trimester 	◆	
	Infant CPR Training Class	<ul style="list-style-type: none"> • Non-certified <ul style="list-style-type: none"> • How to respond if your baby is choking 	◆	
Health and Wellness	Portable Crib/Playpen	<ul style="list-style-type: none"> • After first postpartum visit 21-56 days after delivery 	◆	◆
	Asthma Education Gift Card	<ul style="list-style-type: none"> • \$50 Gift Card (Walmart), upon completion of • Series of 6 Asthma Education Classes 	◆	
	Post Hospitalization Follow-up Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of • Post hospitalization visit within 14 days of discharge • Up to 3 times per member 		
	Diabetes Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), up to 3 cards upon completion of each • Annual diabetic eye exam OR • Biannual HbA1c Blood test (every 6 months) OR • Maintain an under 8 HbA1c blood result every 6 months 	◆	◆
	Cervical Cancer Screening Gift Card	<ul style="list-style-type: none"> • \$20 Gift Card (Walmart), upon completion of screening • Ages 21-64 		
	Smoking Cessation Benefit	<ul style="list-style-type: none"> • Up to \$75 per month for stop-smoking products for tobacco dependent parents of members who agree to coaching 	◆	◆
	24 Hour Nurse Help Line	<ul style="list-style-type: none"> • Nurse staffed phone service line available to member 24 hours a day/ 7 days a week 	◆	◆
Extra Help for Families	Dental Health Services	<ul style="list-style-type: none"> • Comprehensive Oral Exam • 2 routine exams per 12 months • Emergency exams • Ages 21 and up <ul style="list-style-type: none"> • X-rays • Fillings • Routine extractions • 2 cleanings per 12 months 		
	Diapers	<ul style="list-style-type: none"> • Up to 2 free packs of disposable diapers, upon completion of • Wellchild check at the 12- and 15-month intervals (5th & 6th THSteps) 	◆	◆
	Caregiver Respite Care Services	<ul style="list-style-type: none"> • In-home respite services to relieve unpaid primary caregivers • Limited to 8 hours per year 		
	Extra Help Getting A Ride	<ul style="list-style-type: none"> • TCHP will arrange for transportation through vendor OR • TCHP will offer prepaid Gas Card 	◆	◆
	Parent Training Class	<ul style="list-style-type: none"> • TCHP educators will offer parent training seminars on a variety of topics 		
Stay Active!	TCHP Keep Fit Program	<ul style="list-style-type: none"> • Healthy eating material • At home work-out materials • Quarterly newsletter • Assigned health coach <ul style="list-style-type: none"> • Health / fitness sessions • 10 week Weight Watcher program • Ages 10-18 with BMI of 20+ 	◆	◆
	Soccer Clinics, a partnership with the Houston Dynamo	<ul style="list-style-type: none"> • Participation in a soccer clinic • Two tickets to Dynamo game at BBVA Compass Stadium <ul style="list-style-type: none"> • Ages 7-12 	◆	
	Sports Team Fee Assistance	<ul style="list-style-type: none"> • Enrollment and access to any sports/physical activity program available for the member • Up to \$100/year per member 		
	Sports / School Physical	<ul style="list-style-type: none"> • 1 Annual <ul style="list-style-type: none"> • Ages 15-19 	◆	◆
Family Fun	Water Park Day	<ul style="list-style-type: none"> • Access to a local waterpark for the member and their family 	◆	◆
	Movie Day	<ul style="list-style-type: none"> • A private movie screening of new release at the theater with concessions for the members 	◆	◆
	Sensory-Friendly Movie Days	<ul style="list-style-type: none"> • Brighter lighting • Lower sound <ul style="list-style-type: none"> • Shorter previews • Welcoming/accepting environment 		
	Boys and Girls Club of Greater Houston	<ul style="list-style-type: none"> • Free summer and school year membership 	◆	

XXXVIII.

Coordination With Non-CHIP Perinatal Covered Services (Non-Capitated Services)

Texas Children's Health Plan is not responsible for providing the services listed below, but is responsible for appropriate referrals for these services.

Texas Agency Administered Programs and Case Management Services

Texas Children's Health Plan will cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

Children who are served by TDFPS may transition into and out of Texas Children's Health Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area.

During the transition period and beyond, providers must:

- Provide medical records to TDFPS
- Recognize suspected cases of abuse or neglect and appropriately refer to TDFPS
- Schedule medical and behavioral health services appointments within 14 days, unless requested earlier by TDFPS

Essential Public Health Services

Texas Children's Health Plan is required through its contractual relationship with Health and Human Services Commission to coordinate with Public Health Entities regarding the provision of services for essential public health services. Providers must assist Texas Children's Health Plan in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving members.
- Referring to the local public health entity for TB contact investigation and evaluation and preventive treatment of persons with whom the member has come into contact.
- Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons with whom the member has come into contact.
- Referring for Women, Infant and Children (WIC) services.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment.

XXXIX.

Behavioral Health

Expectant mothers enrolled in CHIP Perinatal are not entitled to behavioral health services. Please refer to the CHIP Perinatal Covered Services portion of the manual for information on behavioral health benefits for CHIP Perinatal newborns.

Provider Responsibilities

Expectant Mothers Enrolled in CHIP Perinatal

Expectant mothers enrolled in CHIP Perinatal will not have an assigned primary care provider on their ID card. Since benefits are limited to prenatal care only, there will be a pregnancy care provider listed which may be a family practice physician, OB/GYN physician, internal medicine physician, advanced nurse practitioner, certified nurse midwife, or clinic.

CHIP Perinatal Newborns—Primary Care Provider (Medical Home) Responsibilities

Once the CHIP Perinate mother delivers, Texas Children’s Health Plan will work with the mother to select a primary care provider for her newborn. This can be done by calling Member Services at 832-828-1004.

Health and Human Services Commission encourages providers participating in CHIP Perinatal to practice the “medical home concept” for clients with CHIP Perinatal. To realize the maximum benefit of health care, each family and individual needs to be a participating member of a readily identifiable, community-based medical home. The medical home provides primary medical care and preventive health services and is the individual’s and family’s initial contact point when accessing health care. It is a partnership among the individual and family, health-care providers within the medical home and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship. The providers in the medical home are knowledgeable about the individual’s and family’s specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, specialty/hospital services and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism and accepts them back into the medical home for continuing primary medical care and preventive health services.

The primary care provider either furnishes or arranges for all the client’s health-care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

Availability and Accessibility

Texas Children’s Health Plan members are assured timely access to services and availability of providers within the established standards, as noted below.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 following American Academy of Pediatrics (AAP) periodicity schedule
Newborns	In no case later than 14 days of enrollment and following American Academy of Pediatrics (AAP) periodicity schedule

24-hour Availability

Primary care providers are required to provide 24-hour coverage, seven days a week for Texas Children's Health Plan members. Arrangements for coverage while off-duty or on vacation are to be made with other participating providers. Texas Children's Health Plan should be notified of the provider's coverage prior to a leave of absence.

Texas Children's Health Plan's contracts with primary care providers state that primary care providers must, "be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week." Additionally, primary care provider contracts state that primary care providers must maintain one of the following to receive calls from members after normal business hours:

- The office telephone is answered after-hours by an answering service, which meets the language requirements of the major population groups and which can contact the primary care provider or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- 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 primary care provider or another provider designated by the primary care provider. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after hours to another location where someone will answer the telephone and be able to contact the primary care provider or another designated individual medical practitioner who can return the call within 30 minutes.

Plan Termination

A primary care provider who elects to terminate Texas Children's Health Plan participation must notify Texas Children's Health Plan in writing or his/her respective IPA, if applicable, who in turn notifies Texas Children's Health Plan Provider Relations by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of the provider's contract with Texas Children's Health Plan or the IPA. Texas Children's Health Plan will notify the member in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Texas Children's Health Plan to efficiently transfer patients to another primary care provider. Physicians are requested to continue care in progress until all members can be successfully transferred to a new primary care provider.

Member Education about Member's Right to Designate an OB/GYN

Texas Children's Health Plan members are informed that they have the right to select an OB/GYN without a referral from their primary care provider. Texas Children's Health Plan members may access the health services of an OB/GYN for their annual well woman exam, prenatal care, female medical conditions, and specialist referrals within the network.

Referral to Specialists and Health-related Services

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

The primary care provider or designee may make medically necessary referrals to specialists for family planning, mental health and emergency services without authorization from Texas Children's Health Plan. A list of these providers will be sent to the primary care provider. The following referrals for services require authorizations/notifications:

- All hospital admissions
- DME (Durable Medical Equipment)
- Home health services
- Outpatient surgery
- Pain management
- Therapies – OT, PT, Speech/Hearing
- New pregnancies (call to notify Texas Children's Health Plan of pregnancy)

Referrals to specialists for these services must be submitted to Texas Children's Health Plan by faxing the referral and authorization form to 832-825-8760, calling 832-828-1004 or going to Texas Children's Health Plan online at www.tchp.us/providers. All referring primary care providers will provide the provider and/or specialists with complete information on treatment procedures and diagnostic tests performed prior to the referral. In addition, the primary care provider will remain responsible for ensuring continuity of the member's care by maintaining medical record documentation of treatment rendered.

Authorizations for referrals to in-network specialists are not required. It is recommended that a primary care provider check with Texas Children's Health Plan Member Services to confirm specialist network status. Texas Children's Health Plan does not need a copy of the referral form. **REMINDER: ALL REFERRALS TO SPECIALISTS FOR A CHIP PERINATAL MOTHER MUST BE RELATED TO PREGNANCY CARE ONLY AND SUBJECT TO THE COVERED SERVICES AND BENEFIT LIMITATIONS.**

CHIP Perinatal newborn members with disabilities, special health-care needs, or chronic or complex conditions are allowed direct access to a specialist.

The primary care provider is expected to refer Texas Children's Health Plan members to Texas Children's Health Plan behavioral health providers, as needed, for behavioral health services. Texas Children's Health Plan members may self-refer to behavioral health providers for treatment. The behavioral health provider must attempt to obtain a release of information from the Texas Children's Health Plan member to allow the behavioral health provider and primary care provider to share this information.

The primary care provider's record will include documentation of behavioral health referrals made and the coordination and communication with behavioral health providers regarding the member's treatment.

The specialist is expected to communicate with the primary care provider regarding services rendered as well as results, reports and recommendations. This is essential to ensure continuity of care for the member.

Primary care providers may provide behavioral health related services within the scope of its practice (See Behavioral Health Section III of this manual).

Referral to Network Facilities and Contractors

To authorize services, please call 832-828-1004, fax 832-825-8760, or submit an authorization by visiting Texas Children's Health Plan online at www.tchp.us/providers. To become an authorized user, a provider must fill out the Texas Children's Health Plan Secure Access Application. Contact the Provider Relations representative to get more information.

Members' Right to a Second Opinion

Texas Children's Health Plan members may access a second opinion regarding any health care service.

A member must be allowed access to a second opinion from a network provider or out-of-network provider, if a network provider is not available, at no additional cost to the member.

Specialty Care Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Texas Children's Health Plan members who have been referred by their primary care provider for specified consultation, diagnosis and/or treatment. The specialist must communicate with the primary care provider regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the primary care provider. The specialist should also respond to requests from the Texas Children's Health Plan Utilization Management Department for pertinent clinical information that assists in providing a timely authorization for treatment.

When a Texas Children's Health Plan member receives a specialist referral from his/her primary care provider, the specialist should review the case with the primary care provider to determine clearly what services are being requested. To authorize services, please call 832-828-1004, fax 832-825-8760, or submit an authorization by visiting Texas Children's Health Plan online at www.tchp.us/providers.

Provider shall maintain such offices, equipment, patient services personnel and allied health personnel as may be necessary to provide contracted services.

If provider is a specialty care physician, provider shall ensure that contracted services are provided under this agreement at the specialty care physician's office during normal business hours, and be available to beneficiaries by telephone 24 hours a day, 7 days a week for consultation on medical concerns.

Responsibility to Verify Member Eligibility and/or Authorizations for Service

It is the responsibility of the treating provider to verify that the patient continues to be a Texas Children's Health Plan and a CHIP eligible member for services during the treatment period. Verification of eligibility may be made by:

- Calling Texas Children's Health Plan Member Services at 832-828-1004
- 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. Call Texas Children's Health Plan Provider Relations to get more information).
- Calling the CHIP Provider Eligibility Hotline at 832-828-1004.
- CHIP Provider Eligibility Hotline. CHIP Providers can receive eligibility information by calling the CHIP provider eligibility hotline Monday through Friday 8:00 AM to 5:00 PM (Central Time). The hotline number is 832-828-1004. Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently enrolled CHIP Member.

Continuity of Care

- Pregnant women information. Texas Children's Health Plan will take special care not to disrupt care in progress for newly enrolled members. Pregnant members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN provider through the member's postpartum check-up. A member may change her OB/GYN if she requests.
- Member moves out of service area. Texas Children's Health Plan requests that the member tell us in writing if they move, change their address or phone number, even if these changes are temporary. If a member moves out of the service area, they may no longer be eligible. The service area includes: Austin, Brazoria, Chambers, Ft. Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, and Wharton counties.
- Pre-existing conditions. Texas Children's Health Plan is responsible for providing all covered services to each eligible member beginning on the implementation date or the member's date of enrollment under the contract regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services.

Accessibility and Availability of Medical Records

Texas Children's Health Plan includes provisions in contracts with subcontractors for appropriate access to the medical records of its members for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, state agencies, or any agents thereof.

Texas Children's Health Plan directs that appropriate medical records for the member will be available to health care providers at each encounter.

Record Keeping

Medical records may be on paper or electronic. Texas Children's Health Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review.

- Medical record standards—Texas Children's Health Plan sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards will, at a minimum, include requirements for:
 - Patient identification information—Each page or electronic file in the record contains the patient's name or patient ID number.
 - Personal/biographical data—Includes age, sex, address, employer, home and work telephone numbers, and marital status.
 - All entries are dated and author identified.
 - The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
 - Allergies—Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies—NKA) is noted in an easily recognizable location.
 - Past medical history (for patients seen 3 or more times)—Easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.

- Immunizations—For pediatric records there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Diagnostic information.
- Medication information (includes medication information/instruction to patient).
- Identification of current problems—Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical record.
- Patient is provided basic teaching/instructions regarding physical and/or behavioral health condition.
- Smoking/alcohol/substance abuse—Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.
- Consultations, referrals, and specialist reports—Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
- Hospital discharge summaries—Discharge summaries are included as part of the medical record for:
 - All hospital admissions that occur while the patient is enrolled with Texas Children’s Health Plan.
 - Prior admissions as necessary.
- Prior admissions as necessary pertain to admissions that may have occurred prior to patient being enrolled with Texas Children’s Health Plan, and are pertinent to the patient’s current medical condition.
- Advance directives—For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- A written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.
- Written procedures for release of information and obtaining consent for treatment.
- Documentation of evidence and results of medical, preventive, and behavioral health screening.
- Documentation of all treatment provided and results of such treatment.
- Documentation of the team members involved in the multidisciplinary team of a member needing specialty care.
- Documentation in both the physical and behavioral health records of integration of clinical care. Documentation to include:
 - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated.
 - Screening and referral by behavioral health providers to primary care providers when appropriate.
 - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
 - At least quarterly (or more often if clinically indicated), a summary of status/progress from the behavioral health provider to the primary care provider.
 - A written release of information which will permit specific information sharing between providers.
 - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Patient Visit Data

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and physical examination—Appropriate subjective and objective information is obtained for the presenting complaints.
- For members receiving behavioral health treatment, documentation to include “at risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
- Admission or initial assessment—This includes current support systems or lack of support systems.
- For members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- Plan of treatment—This includes activities/therapies and goals to be carried out.
- Diagnostic tests.
- Therapies and other prescribed regimens—For members who receive behavioral health treatment, documentation will include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.
- Follow-up—Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals and results.
- All other aspects of patient care, including ancillary services.

Record Review Process

Texas Children’s Health Plan has a system (record review process) to assess the content of medical records for legibility, organization, completion, and conformance to its standards.

Justification Regarding Out-of-network Referrals—Including Providers Not Contracted with Texas Children’s Health Plan

The primary care physician may request out-of-plan 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-plan specialty authorizations are needed. Again, specialty authorizations include services which cannot be provided within the Texas Children’s Health Plan network. The out-of-network specialist calls 832-828-1004, faxes 832-825-8760, and/or submits an authorization form online at www.tchp.us/providers. Texas Children’s Health Plan Medical Director or Utilization Management 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.

Options for Member Non-compliance

In the event that a member:

- Becomes non-compliant.
- Becomes abusive to you or your staff.
- Continues to demand services that, in your professional judgment, are not medically necessary.

You should contact Texas Children’s Health Plan Provider Relations at 832-828-1008 so that the problem can be researched and resolved.

Primary care providers may request, in writing to Texas Children’s Health Plan, that a member be transferred to another primary care provider for the following reasons:

- Member is disruptive, unruly, threatening, or uncooperative to the extent that the Member’s membership seriously impairs the provider’s ability to provide services to the member, provided the behavior is not caused by a physical or behavioral health condition.

- Member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition.
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary and the member has received full informed consent regarding the prescribed treatment course.

Providers are not allowed to withhold or discriminate in any way in the treatment of a member or to transfer a member from his/her practice because of the health condition of a member or the amount of services provided. A primary care provider cannot transfer a member to another primary care provider without the prior written authorization of Texas Children's Health Plan's Medical Director. Texas Children's Health Plan requests that the physician continue care until Texas Children's Health Plan can successfully transfer the member to a new primary care provider's care.

Primary care providers shall not refuse to accept a member as a patient on the basis of health status, previous use of services, or the medical condition of the member.

Reporting Changes

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

- 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.

Providers have a minimum of 30 calendar days to inform Texas Children's Health Plan of any changes to the provider data listed above. Changes not received in writing are not valid. If Texas Children's Health Plan is not informed within the aforementioned time frame, Texas Children's Health Plan and its designated claims administrator are not responsible for the potential claims processing and payment errors. Notification of change should be made to Texas Children's Health Plan Provider and Care Coordination.

Network providers must also notify Health and Human Services Commission's administrative services contractor of any change that involves the provider's address.

Routine, Urgent, and Emergent Services

Definitions

Texas Children's Health Plan is committed to ensuring that members receive timely and appropriate level of access to all levels of care—emergent, urgent, routine, and preventive—within the defined timeframes:

Emergent/Emergency

A medical condition that manifests itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in one or all of the following:

- Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- Inadequate time to safely transfer a member, who is pregnant and having contractions, to another hospital before delivery, or if a hospital transfer might pose a threat to the health or safety of the woman or the unborn child.
- Member is a threat to themselves or others; exhibits acute onset of psychosis or severe thought disorganization; risks deterioration from a chronic physical or behavioral health condition that could render the member unmanageable and unable to cooperate in treatment; or needs assessment and treatment in a safe and therapeutic setting.

Emergency room providers are authorized by Texas Children's Health Plan to provide medically necessary and appropriate treatment for any Texas Children's Health Plan member. If a Texas Children's Health Plan member needs to be admitted, the hospital must notify the Texas Children's Health Plan Utilization Management Department within 24 hours of the admission or the next business day, by either calling 832-828-1004, by faxing the encounter record to 832-825-8760, or by going to Texas Children's Health Plan online at www.tchp.us/providers. The primary care provider should also be notified by the hospital about the admission within 24 hours or the next business day.

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	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 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 following American Academy of Pediatrics (AAP) periodicity schedule
Newborns	In no case later than 14 days of enrollment and following American Academy of Pediatrics (AAP) periodicity schedule

Urgent

A health condition including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the member's primary care provider or primary care provider designee to prevent serious deterioration of the member's condition of health.

Routine or Preventive (Non-emergent)

Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. Postponement of treatment will not endanger life, limb, or mental faculties of patient, i.e., patient's condition permits adequate time to schedule necessary history and physical, laboratory, radiology, or other diagnostic studies on an outpatient basis.

Whenever a Texas Children's Health Plan member presents to an emergency room with a non-emergent condition, the member must be assessed and their primary care provider must be contacted (the name of the primary care provider is located on the member ID card) for appropriate treatment or education. Follow-up care should be referred to the PCP.

Emergency Prescription Supply

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

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

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

To be reimbursed for a 72-hour emergency supply please see instructions on page 95.

Emergency Transportation—Ambulance

The ambulance transport is an emergency service when the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

Non-emergency Transportation—Medical Transportation

When a Texas Children's Health Plan member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is a non-emergency service. Non-emergency transports for a Texas Children's Health Plan member with severe disabilities must be to or from a scheduled medical appointment.

A round-trip transfer from the member's home to an outpatient or freestanding dialysis or radiation facility is covered only when the member meets the definition of severely disabled. "Severely disabled" means that the member's physical condition limits his/her mobility and requires the member to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems including oxygen or IV infusion. A run sheet or other supporting documentation is required for non-emergency transportation and must clearly state the member's physical condition and severity at the time of the transfer. The run sheet must include the signature of the EMT transporting the client. Non-emergency transfers of members whose condition does not meet the severely-disabled criteria are not covered benefits.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary or not part of a covered preventive family planning service if both the following conditions are met:

- A specific service or item is provided at the member's request.
- The provider has obtained and kept a written Member Acknowledgement Statement signed by the client that states:
“I understand that, in the opinion of (Provider's name) the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Children's Health Insurance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary.”
“Comprendo que, según la opinión del (nombre del Proveedor), es posible que CHIP (Programa de Seguros Médicos para Niños) no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el HHSC o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

A provider may bill the following to a Member without obtaining a signed Member Acknowledgement Statement:

- Any service that is not a benefit of the CHIP Program or Texas Children's Health Plan's benefit package (for example, personal care items).
- All services incurred on non-covered days because due to lack of eligibility.
- The provider accepts the member as a private pay patient.

Private Pay Form Agreement

Providers must advise members that they are accepted as private pay patient at the time the service is provided and will be responsible for paying for all services received. The member should sign written notification.

The member is accepted as a private pay patient pending CHIP Perinatal eligibility determination and will become eligible for CHIP Perinatal retroactive to the first day of the month determined eligible. The provider is allowed to bill the patient as a private pay. If the member becomes eligible retroactively, the member should notify the provider of the change in status. Ultimately, the provider is responsible for filing timely CHIP Perinatal claims. If the patient becomes eligible, the provider MUST refund any money paid by the patient and file CHIP Perinatal claims for all services rendered.

PRIVATE PAY AGREEMENT

I, _____ understand that the provider _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any service I receive. The provider will not file a claim to CHIP for services provided to me.

Signed: _____

Dated: _____

PACTO DE PAGO PRIVADO

Yo, _____ entiendo que el proveedor _____ me esta aceptando como paciente de pago privado por el periodo de _____, y me hago responsable en pagar por cualquier servicio rendido. El proveedor no le mandara a CHIP ningún reclamo por servicios que me rinda.

Nombre: _____

Fecha: _____

Billing for CHIP Perinatal Services

Claims for Professional Services

Claims for professional services that are covered by CHIP Perinatal can be billed to Texas Children's Health Plan. Please refer to the Overview Section of this manual for detailed billing and claims information.

Texas Children's Health Plan will include payment for postpartum visits to the delivering provider when the delivery is billed with the delivery/postpartum CPT code of 59410 for vaginal deliveries and 59515 for Cesarean deliveries.

Texas Children's Health Plan will provide targeted education to CHIP Perinate members on the importance of returning to the delivering provider for postpartum care to assure the services are a covered benefit.

Important Information about Hospital Claims

Labor with delivery facility claims for Perinatal Mothers will be paid by two sources:

- Claims for mothers at 185% FPL and under will be submitted to the Texas Emergency Medicaid Program. Claims sent to TCHP for these services will be denied as not a covered benefit.
- Claims for Perinate mothers between 186 – 200% of FPL will be submitted to TCHP for payment.

Claims for facility charges for Perinatal mothers 185% FPL and under and can be sent to:

Texas Medicaid and Healthcare Partnership Claims
P.O. Box 200555
Austin, TX 78720-0555

Please check the member's ID card for billing information to avoid delays in claims payment.



CHIP Perinatal Provider Complaints/Appeals

Provider Complaints to Texas Children's Health Plan

As a Texas CHIP Health Plan, it is the policy of Texas Children's Health Plan to adhere to Texas Department of Insurance regulations and the Texas Insurance Code. Providers who are dissatisfied 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 the disenrollment decisions may file a complaint with Texas Children's Health Plan in writing to the following address:

**Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709, NB 8390
Houston, TX 77230**

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.

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. 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. 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.

Provider Complaint/Appeal Process to Texas Department of Insurance and Requesting an Independent Review Organization (IRO)

Complaints and Appeals to the Texas Department of Insurance

A provider may file a CHIP complaint or appeal directly with the Texas Department of Insurance.

To file a CHIP complaint or appeal, please send your correspondence to:

**Texas Department of Insurance
MCO Quality Assurance Section
Mail Code 103-6A
PO Box 149104
Austin, TX 78714-9104**

Independent Review Organization

If a provider has exhausted Texas Children's Health Plan's appeal process for an adverse determination, the provider has a right to an independent review by an Independent Review Organization (IRO). If a member's health condition is life-threatening, the provider or member may request an immediate review by an IRO.

When Texas Children's Health Plan responds to an appeal of an adverse determination, Texas Children's Health Plan shall provide notification as to how to request an IRO review from the Texas Department of Insurance (TDI). The notification shall describe the IRO process and how TDI assigns a request for review to an IRO, and include the form requesting an IRO review.

The IRO Request Form must be completed by the provider and returned to Texas Children's Health Plan to begin the IRO process. The provider must obtain the member's, or member's legal guardian's signature authorizing release of medical information to the IRO.

Texas Children's Health Plan shall notify TDI upon receipt of the request for an independent review.

Texas Department of Insurance shall, within 1 working day of receipt of the request, randomly assign an IRO and notify Texas Children's Health Plan and the IRO of the assignment. TDI shall send notification to the provider no later than 1 working day after the assignment has been made

No later than the third working day after the date that Texas Children's Health Plan receives a request for review, Texas Children's Health Plan shall provide to the assigned IRO a copy of:

- Any medical records of the enrollee in the possession of Texas Children's Health Plan that are relevant to the review.
- Any documents used by Texas Children's Health Plan in making the determinations to be reviewed by the IRO.
- The written notification relating to appeal of adverse determinations by Texas Children's Health Plan.
- Any documentation and written information submitted to Texas Children's Health Plan in support of the appeal.
- A list containing the name, address and phone number of each physician or health-care provider who has provided care to the enrollee and who may have medical records relevant to the appeal.

The IRO must reach a decision within 15 days after receiving the necessary information but no later than 20 days after the IRO receives its assignment. In cases involving life-threatening conditions, the IRO must reach a decision within 5 days after receiving the necessary information.

An IRO review is not available if:

- Texas Children's Health Plan refuses to pay for a service that the Plan does not cover, such as cosmetic surgery.
- A member has already received treatment and Texas Children's Health Plan then determines that the treatment was not medically necessary or appropriate.



Member Complaints/Appeals

If a Texas Children's Health Plan member expresses a desire to file a complaint, providers should direct him or her immediately to Texas Children's Health Plan. Complaints can be filed by calling or writing Member Services:

Texas Children's Health Plan
Attention: Member Services
PO Box 301011, NB 8360
Houston, TX 77230-1011
832-828-1002 or toll-free at 1-866-959-6555

Member advocates are available to give members assistance with filing their complaint and understanding the complaint process.

Within 5 business days of receiving a complaint, Texas Children's Health Plan will send the member a letter to confirm the day received the complaint. If the complaint was filed by calling us, the letter will include a form for the member to complete describing his or her complaint. The member or their authorized representative will need to complete this form and return it prompt resolution. The member can also call Member Services at 832-828-1002 or toll-free at 1-866-959-6555 if they need assistance completing the form.

Texas Children's Health Plan responds to complaints in writing within 30 calendar days. A resolution letter will be mailed to member. The letter will include what we have done to address their complaint.

If a complaint involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan respond based on the immediacy of the case, but not to exceed 1 business day.

If a member is not satisfied with Texas Children's Health Plan's decision on a complaint, the member has the right to appeal, in writing, within 30 days of when he or she gets the complaint response. The appeal will be reviewed by a Complaint Appeal Panel. When Texas Children's Health Plan receives a written appeal or request for a Complaint Appeal Panel, it will send a written acknowledgment letter to the complainant within 5 business days. Within 5 business days from the date the Complaint Appeal Panel meets, Texas Children's Health Plan will send to the complainant all information it will review regarding the complaint the names and physician specialty, (if applicable), of the Complaint Appeal Panel. The complainant may appear in person at Complaint Appeal Panel and present expert testimony supporting his or her position.

Texas Children's Health Plan will complete the appeal process and respond to the complainant's appeal within 30 calendar days from receipt; however, if the complaint appeal involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan will respond based on the immediacy of the case, but not to exceed 1 business day.

In lieu of a Complaint Appeal Panel, Texas Children's Health Plan may request a review by a different physician or provider same or similar specialty who typically manages same type of medical condition.

Member Standard Appeal Process

A member has the right to appeal any services that have been denied by Texas Children's Health Plan because it does not meet the criteria of medical necessity. A denial of this type is called an adverse determination.

Texas Children's Health Plan will notify the provider and member when it issues an adverse determination in accordance with following timeframes: within 1 business day by telephone or electronic transmission to the provider, if hospitalized at time of adverse determination, followed by letter to the member within 3 business days, or 3 business days to the provider and member not hospitalized.

If Texas Children's Health Plan is denying post-stabilization care following an emergency, Texas Children's Health Plan will issue the adverse determination within 1 hour of the request. To appeal an adverse determination, a member may contact Texas Children's Health Plan at the following address:

Texas Children's Health Plan
Attention: Complaint and Appeal Coordinator
Member Services Department
PO Box 301011, NB 8360
Houston, TX 77230-1011
832-828-1002 or toll-free at 1-866-959-6555

The member may contact the Texas Children's Health Plan Member Services Department at the above telephone numbers and a Texas Children's Health Plan member advocate will assist him or her in filing an appeal, if needed.

A member may file an appeal to an adverse determination at any time, but members are encouraged to file their appeal within the first 30 days following the adverse determination.

A member may file an appeal verbally or in writing. When Texas Children's Health Plan receives a written appeal, it will send a written acknowledgment letter to the appellant within 5 business days. If the appeal is received verbally, Texas Children's Health Plan will send the written acknowledgment letter within 5 business days and include one-page appeal form for the appellant, or his or her designated representative, to complete and return to Texas Children's Health Plan at the above address. Texas Children's Health Plan will generally respond to appeals within 30 calendar days; however, if an appeal involves the denial of emergency care or the denial of a continued hospital stay, Texas Children's Health Plan will respond based on the immediacy of the case, but not to exceed 1 business day.

Member Expedited Appeal Process

If a member's health condition would be adversely affected by following the standard appeal process, a member or someone acting on their behalf may request an expedited appeal orally or in writing. These include cases involving denials for emergency care, denials of care for life-threatening conditions, and denials for continued hospital stay. For assistance or to request an expedited review, the member may contact Texas Children's Health Plan at the following:

Texas Children's Health Plan
Attention: Utilization Review
PO Box 301011, NB 8360
Houston, TX 77230-1011

Texas Children's Health Plan clinical staff will evaluate the request for an expedited review and if the situation meets the above criteria, a specialist in the same or similar specialty, who was not involved in the previous decision-making, will review the case and render a decision within 1 business day. If the appeal does not meet the above criteria for an expedited review, the appeal will be handled under the standard appeal timeframes.

Member Complaint/Appeal to Texas Department of Insurance and Requesting an Independent Review

Independent Review Organization Process

Independent Review Organization is an entity that is certified by the Commissioner of Insurance under Insurance Code Article 21.58c to conduct independent review of adverse determinations. A member has a right to appeal to an independent review organization (IRO) if Texas Children's Health Plan makes a determination that treatment that is recommended, but not yet performed, is not medically necessary or appropriate. The independent review system is coordinated through TDI, who assigns the appeal request to an IRO not associated with Texas Children's Health Plan, who then performs a final administrative review to determine medical necessity and appropriateness. The IRO's decision is binding on Texas Children's Health Plan and Texas Children's Health Plan pays for the cost of the IRO.

To request an IRO review, a member must contact Texas Children's Health Plan at the following address:

Texas Children's Health Plan
Attention: Appeals Department
PO Box 301011, NB 8390
Houston, TX 77230

Texas Children's Health Plan will send the member forms to request an IRO review. Once Texas Children's Health Plan receives the forms, we will immediately forward the member's request and any clinical information to TDI for the IRO review. TDI will assign the request to an IRO within 1 business day. If any additional information is required by the IRO, Texas Children's Health Plan must provide that information within 3 business days.

The IRO must reach a decision within 15 calendar days after receiving the necessary information but no later than 20 calendar days after the IRO receives the request. In cases involving life-threatening conditions, the IRO must reach a decision within 5 calendar days after receiving the necessary information but no later than 8 calendar days after the IRO receives the request.

An IRO review is not available if:

- Texas Children's Health Plan refuses to pay for a service that the plan does not cover, such as cosmetic surgery.
- A member has already received treatment and Texas Children's Health Plan then determines that the treatment was not medically necessary or appropriate.

Complaints and appeals to the Texas Department of Insurance

A member may file a CHIP Perinatal complaint or appeal directly with the TDI. To file a CHIP Perinatal complaint or appeal, please send your correspondence to:

**Texas Department of Insurance
Consumer Protection (111-1a)
PO Box 149091
Austin, TX 78714-9104
1-800-252-3439
Fax: 512-475-1771
www.tdi.state.tx.us**



CHIP Perinatal Member Eligibility

Eligibility—12-month Term of Coverage

Expectant mothers who enroll in CHIP Perinatal receive 12 months of continuous coverage for the unborn child from the effective date. The mother receives limited prenatal care benefits and her coverage ends at the time of birth. The CHIP Perinate newborn will be covered for the balance of the twelve months of coverage. At this point, the child may enroll in CHIP or Medicaid based on income and eligibility.

Eligibility for enrollment in CHIP and CHIP Perinatal is determined by the Texas Health and Human Services Commission's Administrative Services Contractor.

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

A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate newborn" if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC's enrollment broker.

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



Verifying Eligibility

All Texas Children's Health Plan members are issued a Texas Children's Health Plan member ID card. When verifying member eligibility, ask for the patient's Texas Children's Health Plan CHIP member ID card. Make a copy of both sides of the card for the member's file. Before providing services, verify that an authorization number for inpatient or outpatient services has been received. Failure to obtain authorization may result in a denial by Texas Children's Health Plan. To verify member eligibility, access one of the following sources 24 hours a day, 7 days a week:




Texas Children's Health Plan website www.tchp.us/providers. Providers must fill out the Texas Children's Health Plan Secure Access Application to become an authorized user. Call Texas Children's Health Plan Provider Relations at 832-828-1008 to get more information.

To check eligibility, benefits, and primary care provider selection, call Texas Children's Health Plan Member Services at 832-828-1004.

Providers can receive eligibility information by calling the CHIP Member Services Hotline Monday through Friday 8 a.m. to 5 p.m. (Central Time). The hotline number is 832-828-1004. Providers who call the hotline can speak with a customer service representative to confirm whether a child is a currently enrolled CHIP member, or receive an automated response if the provider has a CHIP member ID number.

Be sure to have the following information when calling or going to Texas Children's Health Plan's website:

- Member's name.
- Member's identification number.
- Member's designated PCP.

Texas Children's Health Plan Member ID Card	
	 
Effective Date: ID: Group: Name: D.O.B.: PCP Name: PCP Effective Date: PCP Address: PCP Phone: RXBIN: 610602 RXPCN: MCD RXGRP: TCH Texas Children's Health Plan Member Services/Servicios para Miembros de Texas Children's Health Plan: 832-828-1002 or toll-free/o gratis al 1-866-959-6555, 24 hours/7 days a week / 24 horas/todos los días. Nurse Help Line/Línea de Ayuda de Enfermeras: 1-800-686-3831 (TDD); 1-888-259-8652 Behavioral Health & Substance Abuse/Salud mental y abuso de sustancias: 1-800-731-8528, 24 hours/7 days a week / 24 horas/todos los días. Vision Care/Atención de la vista: Envolve Vision: 1-844-520-3711 PBM: Navitus 1-877-908-6023	Copays: OV \$ Non-ER \$ InP \$ RX: Generic \$ Brand \$

Directions for what to do in an emergency: In case of an emergency, call 9-1-1 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia: En caso de emergencia llame al 9-1-1 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.




Notice to providers: Call the Provider Hotline at 832-828-1004 to verify eligibility and benefits. Out-of-network (non-participating provider) services must be pre-authorized. Hospitals must call 832-828-1004 to pre-certify elective admissions. Emergency inpatient admissions require Health Plan notification within 48 hours.

Navitus Pharmacy Help Desk: 1-877-908-6023.

Texas Children's Health Plan
 PO Box 300286, Houston, TX 77230
 File all claims directly to the above address
 Electronic Claims Filing Number: 76048

This nontransferable card is for identification; it does not guarantee coverage.

www.TexasChildrensHealthPlan.org

Texas Children's Health Plan Member ID Card	
	 
Effective Date: ID: Group: Name: D.O.B.: PCP Name: PCP Effective Date: PCP Address: PCP Phone: RXBIN: 610602 RXPCN: MCD RXGRP: TCH Texas Children's Health Plan Member Services/Servicios para Miembros de Texas Children's Health Plan: 832-828-1002 or toll-free/o gratis al 1-866-959-6555, 24 hours/7 days a week / 24 horas/todos los días. Nurse Help Line/Línea de Ayuda de Enfermeras: 1-800-686-3831 (TDD); 1-888-259-8652 Behavioral Health & Substance Abuse/Salud mental y abuso de sustancias: 1-800-731-8528, 24 hours/7 days a week / 24 horas/todos los días. PBM: Navitus 1-877-908-6023	

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Instrucciones en caso de emergencia: En caso de emergencia llame al 9-1-1 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

Notice to providers: Call the Provider Hotline at 832-828-1004 to verify eligibility and benefits. Out-of-network (non-participating provider) services must be pre-authorized. Hospitals must call 832-828-1004 to pre-certify elective admissions. Emergency inpatient admissions require Health Plan notification within 48 hours.

Navitus Pharmacy Help Desk: 1-877-908-6023.

Texas Children's Health Plan
 PO Box 300286, Houston, TX 77230
 File all claims directly to the above address
 Electronic Claims Filing Number: 76048

This nontransferable card is for identification; it does not guarantee coverage.

www.TexasChildrensHealthPlan.org

Application Assistance

Texas Children's Health Plan offers personal assistance to Texas Children's Health Plan members wishing to enroll in Medicaid or CHIP at the end of their CHIP Perinatal enrollment. Keeping benefits going is vital and the application process can be confusing. Texas Children's Health Plan offers personal help at this difficult time.

If a Texas Children's Health Plan member needs assistance with the filing process, please have them call 832-828-1004, and Texas Children's Health Plan will assist them over the phone. If the member needs a renewal form, they should call the CHIP Help Line at 1-800-647-6558 or call Texas Children's Health Plan Member Services to get one.

Rights and Responsibilities

CHIP Perinate (Expectant Mother) Member Rights and Responsibilities

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities

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

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.

CHIP Perinate Newborn Member Rights and Responsibilities

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Meaning, you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides about whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If your child is confirmed to have special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are confirmed to have special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/ gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick and OB/GYN before seeing that doctor without a referral.
11. You have a right to emergency services when you need them if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment in the CHIP Program, depending on your income. Co-payments do not apply to CHIP Perinatal members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other Providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have the right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have agreed upon.
4. If you have a disagreement with your health plan, try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health-care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

Reporting Provider or Recipient Waste, Abuse, or Fraud

If you suspect a client (a person who receives benefits) or a Provider (e.g. doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it. You can report Providers/clients directly to your health plan at:

Texas Children's Health Plan
832-828-1320 or toll-free at 1-866-959-2555
Email: tchpfraudandabuse@texaschildrens.org

Or if you have access to the Internet go to HHSC Office of Inspector General (OIG) website at <http://www.hhs.state.tx.us> and select "Reporting Waste, Abuse or Fraud".

The site provides information on the types of waste, abuse and fraud to report. If you do not have Internet access and prefer to talk to a person, call the Office of Inspector General (OIG) Fraud Hotline at 800-436-6184, or you may send a written statement to the following OIG addresses:


To report Providers, use this address:
Office of Inspector General (OIG)
Medicaid Provider Integrity
Mail Code 1361
PO Box 85200
Austin, TX 78708-5200

To report clients, use this address:
Office of Inspector General (OIG)
General Investigations
Mail Code 1632
PO Box 85200
Austin, TX 78708-5200

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

When reporting a provider (e.g., doctor, dentist, counselor, etc.) provide the following:

- Name, address and phone number of the provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Texas Children's Health Plan CHIP identification number of the provider and facility is helpful
- Type of provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can aid in the investigation

- 
- Dates of events
 - Summary of what happened

When reporting a client (a person who receives benefits) provide the following:

- The person's name
- The person's date of birth, Social Security Number, or case number if available
- The city where the person resides
- Specific details about the waste, abuse or fraud

Billing Members

There are no member co-payments for CHIP Perinatal enrollees. Except for costs associated with non-covered services, a member should be held harmless from all collection efforts.

The CHIP Perinatal member will not be responsible for any payment for Medically Necessary Covered Services covered under CHIP Perinatal.

CHIP Perinatal Member Cost Sharing Schedule

The following table includes maximum CHIP cost sharing amounts. If the MCO and the provider have negotiated a lesser amount for a benefit than the identified co-payment, then the co-payment must be capped at the lesser amount.

The following examples are provided for illustrative purposes only.

Example 1: The MCO and a provider have negotiated a \$23.00 rate for an office visit. If the Member's family income is 185% FPL, the co-payment will be capped at \$23.00 for services provided on or after March 1, 2012.

Example 2: The MCO and a pharmacy provider have negotiated a \$9.30 total reimbursement (dispensing fee + product cost) for a prescription of 800mg of Ibuprofen, 50 tablets. If the Member's family income is 185% FPL, the co-payment will be capped at \$9.30 for that prescription provided on or after March 1, 2012.

Co-payments do not apply, at any income level, to:

1. well-baby and well-child care services, as defined by 42 C.F.R. §457.520;
2. preventative services;
3. pregnancy-related services;
4. Native Americans or Alaskan Natives;
5. Members of the CHIP Perinatal subprogram (Perinates (unborn children) and Perinate Newborns).

An MCO is not responsible for payment of unauthorized non-emergency services provided to a CHIP Member by an out-of-network provider. In such circumstances, the CHIP Member will be responsible for all costs.

CHIP Cost Sharing

Enrollment Fees (for 12-month enrollment period):	Charge
At or below 151% of FPL*	\$0
Above 151% up to and including 186% of FPL	\$35
Above 186% up to and including 201% of FPL	\$50
Co-Pays (per visit):	
At or below 100% of FPL	Charge
Office Visit	\$3
Non-Emergency ER	\$3
Generic Drug	\$0
Brand Drug	\$3
Facility Co-pay, Inpatient	\$15
Cost-sharing Cap	5% (of family's income)**
Above 100% up to and including 151% FPL	Charge
Office Visit	\$5
Non-Emergency ER	\$5
Generic Drug	\$0
Brand Drug	\$5
Facility Co-pay, Inpatient (per admission)	\$35
Cost-sharing Cap	5% (of family's income)**

CHIP Cost Sharing

Co-Pays (per visit):	
Above 151% up to and including 186% FPL	Charge
Office Visit	\$20
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	Charge
Office Visit	\$25
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$125
Cost-sharing Cap	5% (of family's income)**

Effective January 1, 2014.

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

CHIP Perinatal Member Enrollment And Disenrollment From Texas Children's Health Plan

Enrollment/Re-enrollment

Expectant mothers who enroll in CHIP Perinatal receive 12 months of continuous coverage. Families must enroll their child in Medicaid or CHIP prior to the end of the 12 months of coverage to ensure continuous eligibility. Eligibility for enrollment in CHIP and Medicaid is determined by the Texas Health and Human Services Commission's Administrative Services Contractor.

When does an enrolled mother become covered?

Expectant mothers enrolling in CHIP Perinatal are not subject to the 90-day waiting period as in CHIP. The expectant mother will be covered from the beginning of the first month she is determined eligible for the program.

Disenrollment

Disenrollment Due to Loss of CHIP Perinatal Eligibility

Disenrollment may occur if a member loses CHIP Perinatal eligibility. A CHIP Perinatal member will lose CHIP Perinatal eligibility for the following reasons:

- Completion of the end of the 12-month coverage period;
- Change in health insurance status, i.e., a member enrolls in an employer-sponsored health plan;
- Miscarriage resulting in the termination of the pregnancy;
- Death of a member;
- Member permanently moves out of the state;
- Voluntary disenrollment (in writing) is requested by the Perinate mom or acting on behalf of the newborn.

Disenrollment by Texas Children's Health Plan

Texas Children's Health Plan has a limited right to request a member be disenrolled from Texas Children's Health Plan without the member's consent. The Health and Human Services Commission (HHSC) must approve a Texas Children's Health Plan request for disenrollment of a member for cause. HHSC may permit disenrollment of a member under the following circumstances:

- Member misuses or loans members Texas Children's Health Plan membership card to another person to obtain services.
- Member is disruptive, unruly, threatening, or uncooperative to the extent that member's membership seriously impairs MCO's or provider's ability to provide services to member or to obtain new members, and member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g. repeatedly using emergency room in combination with refusing to allow MCO to treat underlying medical condition).
- MCO must take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

MCO must notify the member of MCO's decision to disenroll the member if all reasonable measures have failed to remedy the situation.

If the member disagrees with the decision to disenroll the member from MCO, MCO must notify the member of the availability of the Complaint procedure.

MCO cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Texas Children's Health Plan will not disenroll a member based on a change in the member's health status or because of the amount of Medically Necessary Services that are used to treat the member's condition.

Providers may not take retaliatory action against members.

Health Plan Changes

Once the mother of the CHIP Perinate selects an MCO (if there is a choice of health plans), the CHIP Perinate must remain in this MCO until the end of the CHIP Perinatal continuous eligibility period.

If the mother does not select an MCO within 15 days of receiving the enrollment packet, the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO. This is based on multiple health plans participating in CHIP Perinatal.

All CHIP and CHIP Perinatal members must remain in the same MCO until the end of the CHIP Perinatal continuous eligibility period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program members' information. After the CHIP Perinate newborn's coverage is completed, the child will be added to the existing CHIP Program case. The coverage period for the newly enrolled child will be the remaining period of coverage of the siblings already enrolled in the CHIP Program. At the first CHIP Program renewal after CHIP Perinatal ends, the family may choose a new MCO.

Note: The switch of the CHIP Program members from their MCO to the MCO providing the CHIP Perinatal coverage does not count as their 1 MCO change per year.

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

A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate newborn" if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC's enrollment broker.

Chip Perinatal Members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinatal;
- If the member moves into a different service delivery area; and
- For cause at any time

Special Access Requirements

Interpreter/Translation Services

Some Texas Children's Health Plan members will need help communicating with their providers. While we attempt to assign members to a primary care provider according to language, history, proximity, etc., it may not always be possible to be assigned to a primary care provider who speaks the same language, especially if the member speaks an unusual foreign language. If you are serving a Texas Children's Health Plan member who speaks another language, you can call Member Services at 832-828-1004 to access an interpreter. We usually have Spanish interpreters immediately available. Texas Children's Health Plan also has access to Language Line Services that have interpreters available for more than 140 languages, 24 hours a day, 7 days a week. This service is available by calling Texas Children's Health Plan Member Services Department at 832-828-1004. Once a Texas Children's Health Plan Representative has determined an interpreter is needed, he/she will access the Language Line Service by immediately setting up a conference call between themselves, Language Line Services, and the member.

Below are a few guidelines that result in better communication when using an interpreter:


- Keep your sentences short and concise. The longer and more complex your sentences, the less accurate the interpretation.
- When possible, avoid use of medical terminology that is unlikely to translate well.
- Ask key questions several different ways. This increases the chance that you are obtaining a response to exactly what you need to know.
- Be sensitive to potential patient embarrassment or reticence. It is possible that your question or statements were not accurately translated or understood.
- Ask patients to repeat the instructions you have given. This is a double check on how well they have understood.

Providers can communicate with some hearing impaired members in writing during office visits. Texas Children's Health Plan can help providers communicate with the hearing impaired by telephone with a translation device for the deaf. Call Texas Children's Health Plan Member Services TDD/TTY telephone line at 832-828-1004 for assistance in any language spoken. Some hearing-impaired members, especially those who became deaf prelingually, may not be able to communicate in writing, but can communicate in sign language. Call Member Services to access a signing interpreter.

Provider/Care Coordination

Texas Children's Health Plan will assist the provider in coordinating the care and establishing linkages, as appropriate for our members with existing community-based entities and services, including, but not limited to:

- Maternal and Child Health
- Children with Special Health Care Needs (CHSCN)
- Medically Dependent Children Program (MDCP)
- Community Resource Coordination Groups (CRCGs)
- Texas Department of Assistance and Rehabilitative Services (DARS)
- Home and Community-based Services (HCS)
- Community Based Alternatives (CBA)
- In Home Family Support
- Primary Home Care
- Day Activity and Health Services
- Deaf/Blind Multiple Disabled Waiver Program



Texas Children's Health Plan and providers must ensure members with disabilities or chronic or complex conditions have access to treatment by a multidisciplinary team when determined to be medically necessary for effective treatment, or to avoid separate and fragmented evaluations and service plans. The teams must include both physician and non-physician providers determined to be necessary by the member's primary care provider for the comprehensive treatment of the member. They must:

- Participate in hospital discharge planning.
- Participate in pre-admissions hospital planning for non-emergency hospitalizations.
- Develop specialty care and support service recommendations to be incorporated into the primary care provider's plan of care.
- Provide information to the member and the member's family concerning the specialty care recommendations.

Please contact Texas Children's Health Plan Member Services to assist in coordinating any services that our members may need such as:

- Transportation to a medically necessary appointment.
- Translation services.

Reading/Grade Level Consideration

An estimated 40-44 million Americans are functionally illiterate, and another 50 million are only marginally literate. Nearly half of the functionally illiterate live in poverty and one-fourth report physical, mental, or health conditions that prevent them from participating fully in work, school, or housework. A study of patients at 2 public hospitals found that 35% of the English-speaking and 62% of the Spanish-speaking patients had inadequate or marginal functional health literacy, with more than 81% of the elderly groups having limited health literacy. Thus, we expect that many Texas Children's Health Plan members have limited ability to understand instructions and read medication bottles. Yet, most people with literacy problems are ashamed and will try to hide them from providers.

Low literacy can mean that a patient may not be able to comply with medical advice and prescriptions because they do not understand the instructions.

Member materials should be written at a 4th to 6th grade reading level. The guidelines provided for communication with interpreters are also good guidelines for communicating with members with limited literacy, especially asking the member to repeat those instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines. Above all else, be sensitive to the embarrassment the member may feel about limited literacy. Texas Children's Health Plan Member Services can assist with interpreters.

Cultural Sensitivity

Cultural sensitivity refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each. Texas Children's Health Plan's interpretive services will help to provide care in a culturally competent manner.

Texas Children's Health Plan Members with Special Healthcare Needs

Texas Children's Health Plan members with special health care needs have direct access to a specialist as appropriate for member's conditions and identified needs, as Texas Children's Health Plan does not require prior authorization for in-network specialists.



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