



**Texas Children's[®]
Health Plan**

Texas Children's Health Plan Provider Manual



CHIP and STAR/Medicaid service areas

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

texaschildrenshealthplan.org
832-828-1004 or toll-free 1-800-731-8527



TEXAS STAR
Your Health Plan ★ Your Choice



Provider Quick Reference Guide

Texas Children's Health Plan Provider Relations

Monday - Friday 8:00 a.m. - 5:00 p.m.

Contact us for:

- Updates to provider demographic information
- Requests for supplies (forms, directories, etc.)
- Requests for information on accessing Provider TouCHPoint, Texas Children's Health Plan's web-based provider portal
- Request for educational in-services, CME, and educational material
- Concerns with Texas Children's Health Plan Policies and Procedures

Phone 832-828-1004
Toll-Free 1-800-731-8527
Fax 832-825-8750
Email providerrelations@texaschildrens.org

Provider Complaints

Phone 832-828-1004
Fax 832-825-8750
Email tchpproviderconcerns@texaschildrens.org

Claim Submissions, Corrections, and Appeals

Phone 832-828-1004
Toll-Free 1-800-731-8527
Telephone TouCHPoint 832-828-1007
Website texaschildrenshealthplan.org/for-providers

Submit claims, corrections, and appeals to:

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

- Claims filing deadline is 95 days from date of service
- Appeals deadline is 120 days from date of last disposition of claim
- Please submit claim as "CORRECTED CLAIM"

Electronic Claims Submission

Change Healthcare 866-506-2830 or 877-819-3267
Payor ID STAR 75228 CHIP 76048

Texas Children's Health Plan Refunds Lockbox Address

Texas Children's Health Plan
P.O. Box 841976
Dallas, TX 75284-1976

Texas Children's Health Plan Provider Claims

- Claim inquiry, questions and information about CHIP or STAR
- Eligibility/benefits question on all products

Provider line 832-828-1004
Telephone TouCHPoint 832-828-1007
Provider line 1-800-731-8527
Fax 832-825-8778

State Fair Hearing Contact information

Call 832-828-1004 or 1-866-959-2555, option 1

Texas Children's Health Plan Fraud and Abuse Hotline

Phone 832-828-1320
Fax 832-825-8722
Email TCHPSIU@texaschildrens.org

Contracting

For inquiries 832-828-1004, option 6
Email TCHPNetworkManagement@texaschildrens.org
Fax 832-825-9360

EFT Enrollment and Questions

Change Healthcare

Phone 866-506-2830 or 877-819-3267
Website changehealthcare.com

thecheckup.org

Texas Children's Health Plan's The Checkup makes it easier for providers to stay current on news, announcements, blogs and more. To access, go to thecheckup.org.

Texas Children's Health Plan Provider Portal

Texas Children's Health Plan's online portal offers convenient 24-hour access to:

- Check claim status
- Verify member eligibility
- Check authorization status
- Authorization requests, submissions and utilization guidelines
- Claims appeal submissions
- Batch claims submissions
- Provider education material
- **Clinical practice guidelines are available on the provider portal and our website <http://www.tchp.us/for-providers/provider-resources/practice-guidelines>**

Provider Quick Reference Guide

Texas Children's Health Plan Pharmacy Information

Navitus website navitus.com
Navitus toll free provider hotline 1-877-908-6023
Navitus customer care 1-866-333-2757

Texas Children's Health Plan Women's Health

Phone 832-828-1430
Fax 832-825-8745

Texas Children's Health Plan Care Coordination, Case and Disease Management

Referrals for assistance with chronic or complex conditions, such as asthma, obesity or diabetes and women's health and maternity. Requests for child birth and health education classes.

Phone 832-828-1430
Fax 832-825-8745

Texas Children's Health Plan Nurse Family Partnership

Phone 832-828-1274
Fax 832-825-8710

Texas Children's Health Plan 24-Hour Nurse Help Line

Members have access to registered nurses 24 hours a day, 7 days a week.

Phone 1-800-686-3831

Authorization Information

Please call Texas Children's Health Plan for further information if you are unsure of prior authorization requirements. The list of services are subject to change and will be updated as required.

Phone 832-828-1004
Toll-Free 1-800-731-8527

Medical Prior Authorization Requests

Fax 832-825-8760 or 1-844-473-6860

Behavioral Health Prior Authorization Requests

Fax 832-825-8767 or 1-844-291-7505
Website texaschildrenshealthplan.org/for-providers

Behavioral Health/Substance Abuse Hotline

STAR. 1-800-731-8529
CHIP. 1-800-731-8528

Vision Services

Envolve Vision
CHIP. 1-844-520-3711
STAR. 1-844-683-2305

Dental Services

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

Nonemergency Medical Transportation (NEMT) and Value Added Services (VAS) Transportation

Veyo 1-888-401-0170

Texas Children's Health Plan Laboratory Services

Providers should refer members for laboratory services to an in network labs or State of Texas Laboratories. Some laboratory services may require prior authorization.

texaschildrenshealthplan.org/for-providers/provider-resources

Texas Children's Health Service Coordination

Phone 1-800-659-5764
Fax number 1 346-232-4781
Fax number 2 346-232-4782

Approved Texas HHSC EVV vendors

DataLogic (Vesta) Software, Inc

Phone 1-844-880-2400
Tech Support Email support@vesta.net
Website vestaevv.com

EVV Questions and Concerns

Contact Provider Relations

Phone 832-828-1004
Toll-Free 1-800-731-8527
Fax 832-825-8750

Phone Numbers for State Programs

CHIP Help Line 1-800-647-6558

Early Childhood

Intervention (ECI) 1-877-787-8999, select language, then select option 3

Office of Women's Health

and Education Services 512-458-7796

Texas Health Steps 1-877-847-8377

Women, Infants & Children

Program (WIC) 1-800-942-3678

Vaccine for Children (VFC) . . . 1-800-252-9152, select option 1, then select language

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SECTION I. INTRODUCTION

Welcome to Texas Children's Health Plan.

This Provider Manual contains information about Texas Children's Health Plan's policies and procedures and specific "how to" instructions for STAR and CHIP providers working with Texas Children's Health Plan. As changes occur, we will update the Provider Manual and alert you as necessary. Please visit [texaschildrenshealthplan.org/for-providers](https://www.texaschildrenshealthplan.org/for-providers) for the most up-to-date information.

Our goal is to make working with Texas Children's Health Plan as easy as possible for all providers. If you have any questions about this Provider Manual or need additional information about Texas Children's Health Plan, please contact Texas Children's Health Plan Provider Relations Department at 832-828-1004 or toll-free 1-800-731-8527.

BACKGROUND

Texas Children's Health Plan was founded in 1996 by Texas Children's Hospital. We are the nation's first managed care organization (MCO) created just for children. From the beginning, our goal has been to provide essential health coverage to families in need. Today, Texas Children's Health Plan serves children, teens, pregnant women and adults in the STAR, CHIP and STAR Kids programs in the Harris and Jefferson Service Areas as well as STAR Kids in the Northeast Rural Service Area.

STAR PROGRAM OBJECTIVES

The State of Texas Access Reform (STAR) is a Medicaid-managed care program. The STAR program helps family members of any age. Texas Children's Health Plan offers STAR in 20 counties in the Jefferson and Harris Service Areas.

The objectives of the STAR program are to:

- Provide acute medical care assistance.
- Establish a medical home for members through a Primary Care Provider (PCP).
- Emphasize preventive care.
- Improve access to and quality of care.
- Improve health outcomes.
- Improve client and provider satisfaction.
- Improve cost effectiveness and efficiency.
- Provide disease management.

CHIP PROGRAM OBJECTIVES

The Children's Health Insurance Program (CHIP) offers low-cost health coverage for children from

birth through age 18. CHIP is designed for families who earn too much money to qualify for Medicaid but cannot afford to enroll in other health coverage. Texas Children's Health Plan offers CHIP in 20 counties in the Jefferson and Harris Service Areas.

The objectives of the CHIP program are to:

- Increase the number of insured children in Texas.
- Establish a medical home for clients through a Primary Care Provider (PCP).
- Emphasize preventative care.
- Improve access to and quality of care.
- Improve health outcomes.
- Improve client and provider satisfaction.
- Improve cost effectiveness and efficiency.

STAR KIDS PROGRAM OBJECTIVES

The STAR Kids program is a Medicaid-managed care program providing integrated acute and long-term services and support in a Medicaid-managed care environment for disabled persons (mainly Supplemental Security Income (SSI) eligible Medicaid clients). The STAR Kids program also covers individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID program or an IDD Waiver program (acute care and behavioral health services only – long-term services and supports are provided by the Texas Health and Human Services Commission (HHSC). The program began on November 1, 2016 to children and adults 20 years old and younger with disabilities. Please refer to the STAR Kids Provider Manual for more information on this product.

ELECTRONIC VISIT VERIFICATION (EVV) GENERAL INFORMATION ABOUT EVV

What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;

SECTION I. INTRODUCTION

- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claim.

Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

Which services must a Service Provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services. Visit <https://www.hhs.texas.gov/provider-news/2021/11/02/evv-service-bill-codes-table-version-9-6-updates-star-health>.

Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code,

Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.

- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

Do Providers and FMSAs have a choice of EVV Systems?

Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system. Visit <https://www.tmhp.com/topics/evv/evv-vendors>.
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
 - Is purchased or developed by a Provider or an FMSA.
 - Is used to exchange EVV information with HHSC or an MCO; and
 - Complies with the requirements of Texas Government Code Section 531.024172 or its successors. Visit <https://www.tmhp.com/topics/evv/evv-proprietary-systems>.

Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website. Visit <https://www.tmhp.com/topics/evv/evv-vendors>.
- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process. Visit <https://www.tmhp.com/topics/evv/evv-proprietary-systems>.

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What requirements must a Provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. Visit <https://www.tmhp.com/topics/evv/evv-vendors>;
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
 - An EVV Proprietary System Request Form
 - EVV PSO Detailed Questionnaire (DQ)
 - TMHP Interface Access Request.
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
 - Complete all required EVV training as described in the answer to Question # 18; and
 - Complete the EVV System onboarding activities:
 - Manually enter or electronically import identification data;
 - Enter or verify Member service authorizations;
 - Setup member schedules (if required); and
 - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

Does a Provider or FMSA pay to use the selected EVV System?

- If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an

EVV vendor; or

- Transfer from one EVV Proprietary system to another EVV Proprietary system.

What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
 - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
 - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

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Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
 - Name of the MCO;
 - Name of the Provider or FMSA;
 - Provider or FMSA Tax Identification Number;
 - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
 - Member Medicaid ID;
 - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
 - Authorization start date; and
 - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use

one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

(1) Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
 - the Service Provider's personal smart phone or tablet; or
 - a smart phone or tablet issued by the Provider.
- A Service Provider must not use a Member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
 - the CDS Employee's personal smart phone or tablet;
 - A smart phone or tablet issued by the FMSA; or
 - the CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

(2) Home phone landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another

SECTION I. INTRODUCTION

approved clock in and clock out method.

- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

(3) Alternative device

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the Member's home even during an evacuation.

What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters

inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.

- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance. Visit <https://www.hhs.texas.gov/provider-news/2021/11/02/evv-service-bill-codes-table-version-9-6-updates-star-health>.

SECTION I. INTRODUCTION

EVV TRAINING

What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
 - EVV System training provided by the EVV vendor or EVV PSO;
 - EVV Portal training provided by TMHP; and
 - EVV Policy training provided by HHSC or the MCO.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
 - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked in the EVV System;
 - EVV System training provided by the EVV vendor or EVV PSO;
 - Clock in and clock out methods; and
 - EVV Policy training provided by HHSC, the MCO or FMSA.
 - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
 - EVV System training provided by EVV vendor or EVV PSO; and
 - EVV Policy training provided by HHSC, the MCO or FMSA.
 - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
 - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
 - EVV policy training provided by HHSC, the MCO or FMSA.
- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends. Visit <https://www.tmhp.com/topics/evv/evv-training>.

COMPLIANCE REVIEWS

What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV

requirements and policies. Visit <https://www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook/10000-evv-compliance-reviews>.

- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
 - EVV Usage Review - meet the minimum EVV Usage Score;
 - EVV Required Free Text Review – document EVV required free text; and
 - EVV Landline Phone Verification Review - ensure valid phone type is used.

EVV CLAIMS

Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements. Visit <https://www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook/12000-evv-claims>.

What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

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How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

How can a Provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial. Visit <https://www.tmhp.com/topics/evv/evv-training>.

Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

SECTION I. INTRODUCTION

CONTACTING TEXAS CHILDREN'S HEALTH PLAN

Provider Relations Department

Texas Children's Health Plan has customer service staff ready to assist you with your day-to-day operations, questions and/or concerns. You can contact Texas Children's Health Plan's Provider Relations Department for inquiries such as, but not limited to, Texas Children's Health Plan policies and procedures, contract questions, fee schedule inquiries, how to access our Provider Portal and general program questions. Texas Children's Health Plan's Provider Hotline can be reached by calling 832-828-1004 or toll free at 1-800-731-8527.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

ROLE OF A PRIMARY CARE PROVIDER

Primary Care Providers (PCP) are responsible for the provision of all primary care services for Texas Children's Health Plan STAR and CHIP members.

Credentialed providers in the following specialties can serve as a PCP:

- Pediatrician.
- Family Physician.
- Internist.
- General Practitioner.
- Federally Qualified Health Center.
- Rural Health Clinic.
- Pediatric and Family Advanced Practice Nurse.
- Physician Assistant.
- OB/GYN.
- Certified Nurse Midwives.

A PCP must assess the medical and behavioral health needs of members for referral to specialty care providers, provide referral care as needed, coordinate the member's care with specialty care providers after the referral, and serve as a "medical home" to members. The "medical home" concept establishes a relationship between the PCP and the member in which the PCP provides comprehensive primary care to the member and facilitates partnerships between the physicians, member, acute care and other care providers when appropriate.

ROLE OF THE SPECIALTY CARE PROVIDER (SPECIALIST)

STAR, CHIP and CHIP Perinate Newborn Members

The specialist provides diagnostic treatments and/or management options, tests and treatment plans, as requested by the Primary Care Physician (PCP). PCPs and specialists shall work together to maintain ongoing communication regarding the member's care and treatment. Specialists shall maintain regular hours of operation that are clearly defined and communicated to members. Such access shall include regular office hours on weekdays and call coverage twenty-four (24) hours a day. Treatment for urgent specialty care services must be provided within twenty-four (24) hours of the request.

Specialist as a Primary Care Provider

A specialist may be willing to provide a "medical home" to select members with special needs and conditions.

Members who have disabilities, special health care needs, chronic or complex conditions have the right to request a specialist as a PCP. In order to accept such a request, the specialist must agree to provide all primary care services (i.e. immunizations, well-child care/annual checkups, coordination of all health care services required by the member).

All requests for a specialist to serve as a PCP must be submitted to Texas Children's Health Plan on the Primary Care by Specialist Request Form. The request should contain the following information:

- Description of the medical need for the member to utilize the specialist as a PCP.
- A statement signed by the specialist that he or she is willing to accept responsibility for the coordination of all of the member's health care needs.
- Signature of the member or their legally authorized representative on the completed Primary Care by Specialist Request Form.

The Texas Children's Health Plan Medical Director reviews and determines Texas Children's Health Plan's approval for a specialist to serve as a PCP. The Primary Care by Specialist Request Form is located in the Appendix section of this Provider Manual. You can also access the form by visiting our website at texaschildrenshealthplan.org/for-providers and clicking on the Downloadable Forms link under the "For Providers" section.

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

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

ROLE OF THE CHIP PERINATE PROVIDER

A CHIP Perinate provider provides care for the pregnant woman and her unborn child. Providers who can provide CHIP Perinate prenatal care are limited to physicians, community clinics and providers within the health plan network who offer prenatal care within their scope of practice. This includes family physicians, obstetricians/gynecologists, nurse practitioners and certified nurse midwives.

CHIP Perinate members (unborn children) are categorized into two different groups:

1. At or below the Medicaid eligibility threshold; or
2. Above the Medicaid eligibility threshold.

For CHIP Perinate members at or below the Medicaid eligibility threshold, Texas Children's Health Plan is only responsible for payment of professional services. Hospital/facility charges related to labor and delivery will be covered by Texas Emergency Medicaid.

For CHIP Perinate members above the Medicaid threshold, Texas Children's Health Plan is responsible for payment of both professional and hospital/facility charges related to labor and delivery.

ROLE OF AN OB/GYN

Texas Children's Health Plan allows female members to select any network OB/GYN, without a referral from their Primary Care Provider (PCP). An OB/GYN may also serve as a PCP.

An OB/GYN can provide a member:

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

ROLE OF THE PHARMACY

Texas Children's Health Plan members receive pharmacy services through Navitus Health Solutions (Navitus), Texas Children's Health Plan's contracted Pharmacy Benefits Manager (PBM). Navitus has a statewide network of contracted pharmacies enrolled in the Texas Vendor Drug Program (VDP), including major pharmacy chains and VDP-enrolled independent pharmacies.

Members have the right to obtain Medicaid (STAR) and CHIP covered medications from any Texas Children's Health Plan network pharmacy. The locations of these pharmacies are listed on Texas Children's Health Plan's website at [texaschildrenshealthplan.org/for-providers/provider-resources](https://www.texaschildrenshealthplan.org/for-providers/provider-resources).

Network pharmacies are required to perform prospective and retrospective drug utilization reviews, coordinate with the prescribing physician, ensure members receive all medications for which they are eligible and ensure adherence to the Medicaid (STAR) and CHIP Formularies administered through the VDP and the Medicaid Preferred Drug List (PDL). The network pharmacy must coordinate the benefits when a member also receives Medicare Part D services or has other benefits. Additional pharmacy information is located in the Covered Services section of this Provider Manual.

ROLE OF A DENTAL PROVIDER

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.

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. Additional dental services information is located in the Covered Services section of this Provider Manual.

Helping Members 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 five (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.

VISION SERVICES

Texas Children's Health Plan has contracted with a vision provider, Envolve Vision, for routine vision screenings. A vision screening is an examination by an optometrist

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

or other provider to determine the need for and to prescribe corrective lenses and frames. The providers for these services are listed in the online provider directory for vision benefits located at visionbenefits.envolvehealth.com or members may contact Envolve Vision directly at 1-844-683-2305 (STAR) or 1-844-520-3711 (CHIP).

Members may select and have access to, without a Primary Care Provider (PCP) referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery. For a medical diagnosis, the member should contact their PCP to be referred to an ophthalmologist.

NETWORK LIMITATIONS

Texas Children's Health Plan members must seek services from Texas Children's Health Plan network providers. Providers may refer members to any specialist or OB/GYN within Texas Children's Health Plan's network. Providers must ensure that all necessary prior authorizations are obtained prior to providing services. Please refer to the Prior Authorization Reference Information on our website at texaschildrenshealthplan.org/for-providers under "Provider Resources".

REFERRALS

A Primary Care Provider (PCP) may arrange for a referral to a network specialist when a member requires specialty care services. A specialist may refer to another network specialist if the PCP is notified and concurs with the referral. PCPs are responsible for coordinating appropriate referrals to other network providers and specialists, as well as managing, monitoring and documenting the services of other providers. Referral documentation must be included in the member's medical record.

Referrals from a network PCP to a network specialist (for evaluation only), network facility or contractor do NOT require prior authorization. Some treatment(s) may require a prior authorization when performed by a network provider. Providers are encouraged to review the Prior Authorization Reference Information on our website at texaschildrenshealthplan.org/for-providers under "Provider Resources" for treatments requiring authorization.

If a PCP determines that a member needs to be referred to an out-of-network provider, including medical partners not contracted with Texas Children's

Health Plan, documentation demonstrating the need must be submitted for review and prior authorization. All out-of-network referrals MUST receive prior authorization from Texas Children's Health Plan before the out-of-network referral can occur.

Providers are responsible for initiating the prior authorization process when a member requires medical services that require prior authorization, including inpatient admission.

ACCESS TO SECOND OPINION

Texas Children's Health Plan ensures that each member has the right to a second opinion regarding the use of any medically necessary covered service. Either a member or a network provider may request a second opinion. The second opinion must be obtained from a network provider. If a network provider is not available, the member may obtain the second opinion from an out-of-network provider at no additional cost to the member. A prior authorization is required prior to obtaining a second opinion from an out-of-network provider.

VERIFYING MEMBER ELIGIBILITY

Prior to providing care to members, providers are responsible for:

- Verifying a member's eligibility.
- Identifying which health plan a member is assigned to.
- Identifying the name of the assigned Primary Care Provider (PCP).
- Verifying covered services.
- Obtaining prior authorization for covered services, as applicable.

Providers may verify eligibility through member ID cards, telephone verification, membership listings and through Texas Children's Health Plan's Provider Portal at texaschildrenshealthplan.org/for-providers. Texas Children's Health Plan recommends that providers verify eligibility through all available means prior to providing care to members.

Additional information on verifying eligibility is located in the Member Enrollment and Eligibility section of this Provider Manual.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

AVAILABILITY AND ACCESSIBILITY

Appointment Availability

Texas Children's Health Plan is dedicated to arranging access to care for our members. Access to Primary Care Providers (PCP), specialists, ancillary providers, and network facility providers must be available to members for routine, urgent, and emergent care as noted in the table below.

Type of Care	Appointment Availability
Emergency care	Immediately upon member presentation at the service delivery site.
Urgent care	Within twenty-four (24) hours of request, including urgent specialty care.
Routine primary care	Within fourteen (14) calendar days of request.
Routine specialty care	Within twenty-one (21) days of request.
Preventative health services for adults	Within three (3) months of request.
Preventative health services for children	Within fourteen (14) calendar days for members less than six (6) months of age; within two (2) months for members six (6) months through age twenty (20); for existing members age thirty-six (36) months and older the Texas Health Step annual medical checkup is due on the child's birthday.
Routine prenatal care	Within fourteen (14) calendar days of request.
High risk pregnancy or new member in the third trimester	Within five (5) calendar days of request or immediately if an emergency exists.
Behavioral health	For initial outpatient visit, appointment is within fourteen (14) calendar days of the request. This does not apply to CHIP Perinate members.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

After Hours Access

Texas Children's Health Plan's PCPs must be accessible to members twenty-four (24) hours a day, seven (7) days a week. It is important to keep Texas Children's Health Plan updated with changes to your on-call providers. The provider must comply with the following after-hours telephone availability standards:

- Office phone is answered during normal business hours.
- After business hours, provider must have one of the following arrangements:
 - Office telephone is answered after-hours by an answering service that meets the language requirement of the major population groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within thirty (30) minutes.
 - Office telephone is answered after normal business hours by a recording in the language of each major population group served, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
 - Office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical provider, who can return the call within thirty (30) minutes.

Examples of unacceptable after-hours coverage include:

- Office telephone is only answered during office hours.
- 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 thirty (30) minutes.
- Office telephone is answered after hours by a recording that tells patient to leave a message.

Monitoring Access

Texas Children's Health Plan is required to systematically and regularly verify that covered services furnished by network providers are available and accessible to members in compliance with the standards established by Texas Health and Human Services Commission (HHSC). Texas Children's Health Plan will periodically utilize a challenge survey to verify provider information and monitor adherence to provider requirements.

At a minimum, the challenge survey will include verification for the following elements:

- Provider name.
- Address.
- Phone number.
- Office hours.
- Days of operation.
- Practice limitations.
- Languages spoken.
- Provider type/ provider specialty.
- Length of time a patient must wait between scheduling an appointment and receiving treatment.
- Accepting new patients (PCPs only).
- Texas Health Steps provider (PCPs only).

Texas Children's Health Plan will enforce access and other network standards as required by Texas HHSC and take appropriate action with noncompliant providers.

ROUTINE, URGENT AND EMERGENCY SERVICES

Texas Children's Health Plan follows the Texas Health and Human Services Commission (HHSC) definition of emergency medical condition and emergency behavioral health condition. Based on the following definitions, Texas Children's Health Plan members may seek care from any provider in an office, clinic or emergency room. Treatment for emergency conditions does not require prior authorization or a referral from the member's Primary Care Provider (PCP). Emergency care staff should contact the member's PCP or Texas Children's Health Plan at 832-828-1004, if a member presents with a non-emergent condition.

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Routine Care

Routine care is health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. A non-emergent condition is a condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical or diagnostic studies prior to diagnosis and treatment.

Urgent Condition

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 twenty-four (24) hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.

Urgent behavioral health situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the member in immediate danger to himself or herself or others and the member is able to cooperate with treatment.

Emergency Medical Condition

An 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 member'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 the woman or her unborn child.

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

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

Texas Children's Health Plan will pay for professional, facility and ancillary services provided in a hospital emergency department that are medically necessary to perform the medical screening examination and stabilization of a member presenting with an emergency medical condition or an emergency behavioral health condition, whether rendered by network providers or out-of-network providers. If a member needs to be admitted, the hospital must notify the Texas Children's Health Plan Utilization Management Department within twenty-four (24) hours of the admission by calling 1-832-828-1004 or by faxing the encounter record to 1-832-825-8760.

Network providers have three (3) business days to notify Texas Children's Health Plan of emergent services and are to request non-emergent services seven (7) days in advance of dates of service.

When a service requiring prior authorization is unanticipated (e.g., emergent or unplanned), Texas Children's Health Plan will accept the prior authorization request within three (3) business days. Authorization will be granted based on the request meeting Texas Children's Health Plan's guidelines for the service requested.

AMBULANCE TRANSPORTATION

Texas Children's Health Plan covers emergency and medically necessary non-emergency ambulance transportation.

Emergency Ambulance Transportation

In the event a member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Texas Children's Health Plan prior authorization.

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Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 Tex. Admin. Code § 353.2, is not available at the first facility.

Texas Children's Health Plan requires contracted ambulance providers to comply with the Texas Medicaid Provider Procedures Manual (TMPPM) for emergency ambulance claims. This guidance is available in the TMPPM Ambulance Services Handbook which can be located at <https://www.tmhp.com/resources/provider-manuals/tmpm>.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is defined as ambulance transport provided for a Texas Children's Health Plan member to or from a scheduled medical appointment, to or from a licensed facility for treatment or to the member's home after discharge when the member has a medical condition such that the use of ambulance is the only appropriate means of transportation. Non-emergency ambulance transportation services must be pre-authorized and coordinated by Texas Children's Health Plan before an ambulance is used to transport a member in circumstances not involving an emergency.

Prior authorization requests for non-emergency ambulance transportation must be submitted by the member's provider of record. The provider of record is defined as the physician, doctor or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the member or the physician, doctor or other health care provider that has rendered or has been requested to provide the health care services to the member.

Ambulance provider cannot request prior authorization for these services; however, they may coordinate the exchange of information such as their National Provider Identification (NPI) number and other business information to facilitate communication.

The provider of record or those acting on their behalf may request approval for an ambulance by using the Texas Standard Prior Authorization Request Form for Health Care Services located in the Appendix section of this Provider Manual and on our website at texaschildrenshealthplan.org/for-providers/resources/downloadable-forms under "Authorizations."

EMERGENCY CARE

Texas Children's Health Plan covers emergency services

for current members regardless of the location. Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the member'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 the woman or her unborn child.

The provider should direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition or emergency behavioral health condition exists. If an emergency condition does not exist, the emergency provider should direct the member to their Texas Children's Health Plan Primary Care Provider (PCP).

Texas Children's Health Plan does not require that the member receive approval from their PCP prior to accessing emergency care. To facilitate continuity of care, Texas Children's Health Plan instructs members to notify their PCP as soon as possible after receiving emergency care.

If the provider receives a request for authorization of post-stabilization treatment, the provider must respond to the emergent/urgent facility within one (1) hour. If the facility does not receive a response within one (1) hour, the post-stabilization services shall be considered authorized in accordance with Texas Department of Insurance statutes. The provider shall notify Texas Children's Health Plan of all post-stabilization treatment requests.

CONTINUITY OF CARE

Texas Children's Health Plan takes special care to provide continuity in the care of newly enrolled members for medically necessary covered services regardless of pre-existing conditions, whose physical or behavioral health condition could be placed in jeopardy if medically necessary covered services are

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

disrupted or interrupted.

Texas Children's Health Plan allows a pregnant member past the 24th week of pregnancy to remain under the care of her current OB/GYN through her postpartum checkup, even if the provider is out-of-network. If a member wants to change her OB/GYN to one who is in the Texas Children's Health Plan network, she is allowed to do so as long as the provider agrees to accept her care in the last trimester of pregnancy.

Texas Children's Health Plan will continue to provide and coordinate services for members who move out of the service area through the end of the period for which capitation has been paid for the member.

Additional information related to continuity of care is located in the Covered Services section of this Provider Manual.

ADVANCE DIRECTIVES

Providers must inform Texas Children's Health Plan members, eighteen (18) years of age and older, of their rights to be involved in decisions regarding their medical care. This includes documentation of advance directives, their right to refuse, withhold or withdraw medical and mental treatment and the rights of the member or member's representative to facilitate medical care or make treatment decisions when the member is unable to do so as stipulated in Advance Directives Act, Chapter 166, Texas Health and Safety Code.

Providers must document such information in the member's permanent medical record. Primary Care Providers (PCPs) are responsible for informing their patients about completing an advance directive. The forms can be found at hhs.texas.gov/laws-regulations/forms/advance-directives.

TEXAS VACCINES FOR CHILDREN PROGRAM

The Texas Vaccines for Children Program (TVFC) provides free vaccines for Medicaid (STAR) and CHIP members from birth through eighteen (18) years of age. Vaccines/toxoids must be obtained from TVFC for eligible members from birth through age eighteen (18). Qualified Medicaid (STAR) and CHIP providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page dshs.state.tx.us/immunize/tvfc/info-for-providers.aspx.

NOTIFICATION OF UPDATES IN PROVIDER INFORMATION

Network providers must inform both Texas Children's Health Plan and the Health and Human Services administrative services contractor of any changes to the provider's contact information including address, telephone and fax number, group affiliation, etc. Providers must also ensure that Texas Children's Health Plan has current billing information on file to facilitate accurate payment delivery.

These changes may be reported on the Provider Information Change Form located in the Appendix section of this Provider manual and on our website at texaschildrenshealthplan.org/for-providers/resources/downloadable-forms under "Other Forms." The completed form can be faxed to Provider Network Management at 1-832-825-8750.

NOTIFICATION OF UPDATES TO PANEL STATUS AND RESTRICTIONS

Network providers must inform Texas Children's Health Plan of any changes to their panel status such as an update from a closed panel to an open panel. Providers must also notify Texas Children's Health Plan of any changes to age restrictions. These changes are reflected in print and online directories to assist members in locating a provider. Please submit changes in writing using the Provider Information Change Form located in the Appendix section of this Provider manual and on our website at texaschildrenshealthplan.org/for-providers/resources/downloadable-forms under "Other Forms." The completed form can be faxed to Texas Children's Health Plan's Provider Network Management at 1-832-825-8750.

CREDENTIALING AND RE-CREDENTIALING

To participate in the Texas Children's Health Plan network, all providers must meet the qualifications specific to Texas Children's Health Plan along with government regulations and standards of approved accrediting bodies. Providers must submit all requested information in order to complete the credentialing or re-credentialing process. The re-credentialing process will occur at least every three (3) years or as directed by Texas Health and Human Services Commission (HHSC).

Texas Children's Health Plan has adopted CAQH (Council for Affordable Quality Healthcare, Inc.) for initial credentialing and re-credentialing for our

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

provider network. To learn more about CAQH, call 1-888-599-1771 or visit their website at caqh.org/. Providers not registered with CAQH should refer to the most current Texas Standardized Credentialing Application (TSCA) located on our website at texaschildrenshealthplan.org/for-providers.

All credentialing and re-credentialing questions should be directed to Texas Children's Health Plan's Credentialing Department at 1-832-733-1150.

Providers joining an existing provider group may qualify for expedited credentialing. Please contact our Provider Network Management Department at the following for more information:

Provider Network Management:
1-832-828-1004, option 6
Fax: 1-832-825-9360
Email: tchpnetworkmanagement@texaschildrens.org

TERMINATION

Provider Requests Termination

A provider may terminate from Texas Children's health Plan's network in accordance with the provider's contract. Termination notifications must be received ninety (90) days prior to the termination effective date. Providers may submit their termination request in a number of different ways:

- The provider portal, via the completed provider termination form
- An email sent to providerrelations@texaschildrens.org
- Faxed letter 832-825-8750
- Mailed letter to the following address:
Texas Children's Health Plan
Network Management Department
Attention: President
P.O. Box 301011, WLS 8303
Houston, TX 77230-1011

A termination request must include ALL of the following elements in order to process the request timely. Written letter from provider (on letterhead) or group which includes:

- Provider Name
- Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- Provider Type (PCP or Non-PCP)
- Change type Non delegate or delegate
- Type of Termination (Termination from Health

Plan/Termination from Provider Group/ or Line Of Business such as STAR CHIP or STARKIDS)

- Termination Reason
- Termination Effective Date
- LOB to Term (CHIP, STAR, STARKids)
- Provider Group Name
- PCP Roster report if it's a PCP (if zero members to be moved still attach)
- Member notification report if it's a specialist (if zero members to be notified still attach)
- New PCP name & NPI to assign or move members to
- New Group Affiliation and New Group NPI to move members to

All of the above elements are required to be submitted on the termination request form for termination processing. If any of the above data elements are missing or unknown, the Provider Relations Liaison will reject the termination request back to the requestor for more information.

Texas Children's Health Plan will notify members of the termination and will coordinate care with the provider to ensure continued access to covered services as appropriate.

Termination of Provider by Texas Children's Health Plan

Texas Children's Health Plan may terminate a provider's participation in the health plan in accordance with its contract with the provider and any applicable appeal procedures. Texas Children's Health Plan will follow the procedures outlined in § 843.306 of the Texas Insurance Code if terminating a contract with a provider.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Texas Children's Health Plan works with Texas Department of Family and Protective Services (DFPS) 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 for a child moving between custodians and beyond, providers must:

- Provide medical records to DFPS upon request.
- Refer suspected cases of abuse or neglect to DFPS.
- Schedule medical or behavioral appointments within fourteen (14) days unless requested earlier by DFPS.
- Provide periodic written updates on the treatment status of members to DFPS as required.
- Participate, when requested by DFPS, in planning to establish permanent homes for members.
- Testify in court for child protection litigation as required by DFPS.
- Comply with DFPS policy regarding medical consent and release of confidential information.

REPORTING ABUSE, NEGLECT OR EXPLOITATION

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

Report to Texas Health and Human Services Commission (HHSC)

Report to Texas Health and Human Services Commission (HHSC) 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 Texas HHSC;
- Adult day care centers; or
- Licensed adult foster care providers.

Contact Texas HHSC at 1-800-458-9858.

Report to the Department of Family and Protective Services (DFPS)

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 Texas HHSC;
 - 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 txabusehotline.org.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

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, Texas HHSC, 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, Texas HHSC, 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.

Providers must provide Texas Children's Health Plan with a copy of the ANE report findings within one (1) business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Providers are required to train staff and inform members on how to report ANE in accordance with Texas Human Resources Code, section 48 and Texas Family Code, section 261.

FRAUD, WASTE AND ABUSE PREVENTION

The Medicaid (STAR) and CHIP programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of Texas Children's Health Plan providers in prevention and reporting of potential fraud, waste or abuse. Texas Children's Health Plan has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501- 353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. It is your responsibility as a participating provider to report any member or provider suspected of potential fraud, waste or abuse. All reports will remain confidential.

Reporting Fraud, Waste or Abuse

Let us know if you think a doctor, dentist, pharmacy, and/or a member is committing potential fraud, waste and/or abuse. Potential fraud, waste and abuse examples include but are not limited to:

- Being paid for services that were not given or necessary.
- Not telling the truth about a medical condition to receive medical treatment.
- Letting someone else use a Medicaid (STAR) or CHIP ID.
- Using someone else's Medicaid (STAR) or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.
- Intentional misrepresentation made to receive payments or benefits.
- Overuse or misuse of services that are inconsistent with sound medical, business or fiscal practices.
- Extravagant, careless or needless expenditure of government funds.

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/> Click on the red box at the top right of the screen labeled "Report Fraud" to complete the online form
- You can report directly to Texas Children's Health Plan at:

Email: TCHPSIU@texaschildrens.org

Fax: 832-825-8722

Mail: Texas Children's Health Plan, Controls and Compliance Department

P. O. Box 301011

Houston, TX 77230-1011

1-832-828-1320

Information Needed to Report Fraud, Waste or Abuse

When reporting a provider (doctor, dentist, therapist, pharmacist, etc.) include as much information as possible:

- 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.

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- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Date(s) the situation occurred.
- Specific details about the potential fraud, waste and/or abuse.

When reporting a member (a person who receives 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.
- Date(s) the situation occurred.
- Specific details about the potential fraud, waste and/or abuse.

PROVIDER MARKETING

Providers must adhere to marketing guidelines as outlined by Texas Health and Human Services Commission (HHSC) and referenced in your Texas Children's Health Plan contract for the STAR and CHIP programs. Texas HHSC's marketing guidelines include the following:

1. Providers are permitted to inform their patients about the CHIP and Medicaid Managed Care Programs in which they participate.
2. Providers may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, providers must not recommend one MCO over another MCO, offer patients incentives to select one MCO over another MCO or assist the patient in deciding to select a specific MCO.
3. At the patients' request, providers may give patients the information necessary to contact a particular MCO or refer the member to an MCO Member Orientation.
4. Providers must distribute or display health-related materials for all contracted MCOs or choose not to distribute or display for any contracted MCO:
 - a. Health-related posters cannot be larger than 16" x 24".
 - b. Health-related materials may have the MCO's name, logo, and contact information.

c. Providers are not required to distribute or display all health-related materials provided by each MCO with whom they contract. A provider can choose which items to distribute or display as long as the provider distributes or displays one or more items from each contracted MCO that distributes items to the provider and the provider does not give the appearance of supporting one MCO over another.

5. Providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7" and cannot indicate anything more than "MCO is accepted or welcomed here."
6. Providers may choose whether to display items such as children's books, coloring books and pencils provided by each contracted MCO. Providers can choose which items to display as long as they display one or more from each contracted MCO. Items may only be displayed in common areas.
7. Providers may distribute applications to families of uninsured children and assist them with completing the application.
8. Providers may direct patients to enroll in the CHIP or Medicaid Managed Care Programs by calling the Administrative Services Contractor.
9. Bargains, premiums or other considerations on prescriptions may not be advertised in any manner in order to influence a member's choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the Medicaid/CHIP program.

REQUIRED MEDICAL RECORD DOCUMENTATION

Medical records may be on paper or electronic. Texas Children's Health Plan requires that records be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

Texas Children's Health Plan has adopted the following standards regarding medical records. The records must reflect all aspects of patient care, including ancillary services. At a minimum, medical records must include:

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

- Written policy regarding confidentiality and safeguarding of patient information; records are protected through secure storage with limited access.
- Records are organized, consistent and easily retrieved at the time of each visit. Written procedure for release of information and obtaining consent for treatment.
- Each page or electronic file in the record contains the patient's name and ID number.
- Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.
- All entries are dated (month, day and year) and contain author identification.
- All entries are legible to someone other than the writer.
- The history and physical exam records appropriate subjective and objective information for presenting complaints.
- Problem list documenting significant illnesses, behavioral health and/or medical conditions; unresolved problems from previous office visits are addressed in subsequent visits.
- Medication lists include instructions to patient regarding dosage, initial date of prescription and number of refills.
- Medical allergies and adverse reactions are prominently documented in a uniformed location in the medical record. If no known allergy, NKA or NKDA is documented.
- An immunization record is established for pediatric patients or an appropriate history is made in chart for adults.
- Past medical history (for patient seen three (3) or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries and ER encounters. For children and adolescents (eighteen (18) years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.
- Consultation lab/imaging reports and other studies are ordered, as appropriate. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries are initialed by the ordering practitioner (or other documentation of review) to signify review.
- All working diagnoses and treatment plans are consistent with findings. Ancillary tests and/or services (diagnostic and therapeutic) ordered by practitioner are documented; encounter forms or notes include follow-up care, calls or visits, with specific time of return noted in weeks, months or when necessary, and include follow up of outcomes and summaries of treatment rendered elsewhere.
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).
- Health teaching and/or counseling is documented. If a consultation is requested, there is a note from the consultant in the record.
- For patients ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for patients seen three (3) or more times, substance use history should be queried).
- Documentation of failure to keep an appointment.
- Evidence that an advance directive has been discussed with adults eighteen (18) years of age and older.

Medical records, including electronic medical records, must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. Medical records should be kept in a secure location and accessible only by authorized personnel.

CULTURAL COMPETENCY

Reading/Grade Level Consideration

All Texas Children's Health Plan member materials, such as the Member Handbook and correspondence, are written at a 6th grade reading level in both English and Spanish. Other languages will be provided when the language required is spoken by ten (10) percent or more of the enrolled population.

SECTION II. PROVIDER ROLES & RESPONSIBILITIES

Sensitivity and Awareness

Texas Children's Health Plan places great emphasis on the wellness of its members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with patients and, in the long run, the health and wellness of the patients themselves. We encourage all providers to be sensitive to varying cultures in the community.

Language Translation Services

Texas Children's Health Plan provides several options for the non-English speaking or hearing impaired members (or their parents) to communicate with the health plan. Texas Children's Health Plan will coordinate language translation services with the provider as needed. These options include the following:

- A Member Services department that is staffed with bilingual personnel (Spanish and English).
- Trained professional language interpreters, including American Sign Language, are available for face-to-face communication at your office, if necessary, or via telephone to assist providers with discussing technical, medical or treatment information with members.
- A link to language interpreter services is available twenty-four (24) hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- TTY (text telephone use of telephones for the hearing impaired) access for members who are hearing impaired. This is Relay Texas, 1-800-735-2989.
- Texas Children's Health Plan member and health education materials are available in English and Spanish.

To access interpreter services for your patients, contact Texas Children's Health Plan's Member Services Department at 832-828-1001 (STAR) or 832-828-1002 (CHIP).

SECTION III. MEMBER ELIGIBILITY AND ENROLLMENT

Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid (STAR) and CHIP eligibility. The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the Medicaid (STAR) and CHIP programs. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at 1-800-964-2777. When a member gains Medicaid (STAR) or CHIP eligibility, the state's Enrollment Broker sends the member an enrollment packet, informing the member of the health plan choices in his or her area. The packet will also inform the member to select a health plan and a Primary Care Provider (PCP) within fifteen (15) days. Members applying for CHIP will need to select a plan and a PCP within fifteen (15) days of gaining eligibility.

VERIFYING MEMBER ELIGIBILITY

Verifying Medicaid Member Eligibility

Each person approved for Medicaid (STAR) 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:

- Use TexMedConnect on the Texas Medicaid & Healthcare Partnership (TMHP) website at 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.

Verifying Health Plan Eligibility

Providers are responsible for verifying a member's eligibility, identifying which health plan a member is assigned to, identifying the name of the assigned Primary Care Provider (PCP) and verifying covered services and if they require prior authorization for each visit prior to providing care to members. There are several ways this can be done: through member identification cards, telephone verification, membership listings and through Texas Children's Health Plan's Provider Portal.

Texas Children's Health Plan recommends providers verify eligibility through all available means prior to providing care to members. We provide the following resources:

Telephone TouCHPoint
832-828-1007

Provider Portal
texaschildrenshealthplan.org/for-providers

Member Services
832-828-1001 or 1-866-959-2555 (STAR)
832-828-1002 or 1-866-959-6555 (CHIP)

Texas Children's Health Plan Identification Card

The Texas Children's Health Plan member ID card identifies the health plan and PCP that has been selected by the member. The card includes the following essential information:

- Member name.
- Member ID number.
- PCP's name and telephone number.
- Effective date for PCP.

While the Texas Children's Health Plan ID card does identify the member, it does not confirm eligibility. This is because member eligibility can change on a monthly basis without notice. Providers should use all available resources to confirm current member eligibility prior to rendering services. PCPs should not treat any member whose identification materials identify a different PCP or health plan.

An example of a Texas Children's Health Plan member ID card is located in the Appendix section of this Provider Manual.

Important: Members can request a new card by calling 1-855-827-3748, option one (1) after the language selection. Members can also go online to order new cards or print temporary cards at yourtexasbenefits.com, as well as see their benefit and case information, view Texas Health Steps Alerts and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

SECTION III. MEMBER ELIGIBILITY AND ENROLLMENT

Member Listing for Primary Care Providers

Each PCP has access to a listing of members who selected that provider as their PCP. The membership listing is available on Texas Children's Health Plan's Provider Portal at texaschildrenshealthplan.org/for-providers.

Your Texas Benefits Medicaid Card

Your Texas Benefits give 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 (fee-for-service 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 yourtexasbenefits.com. Your Texas Benefits allows providers to:

- View available health information such as:
 - Vaccinations.
 - Prescription drugs.
 - Past Medicaid visits.
 - Health events, including diagnosis and treatment.
 - Lab results.
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Patients can also log in to 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.

Temporary Medicaid Identification

When a patient's Your Texas Benefits Medicaid card has been lost or stolen, Texas Health and Human Services Commission (HHSC) issues a temporary Medicaid verification Form H1027-A. The Medicaid Eligibility Verification (Form H1027-A) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept the temporary form as valid proof of eligibility and contact the managed care health plan to confirm current eligibility. If the patient is not eligible for medical assistance or certain benefits, the patient is treated as a private pay patient.

Automated Inquiry System

The Automated Inquiry System (AIS) is the contact for prompt answers to Medicaid patient eligibility, appeals, claim status inquiries, benefit limitations and check amounts. Contact the TMHP Contact Center or AIS at 1-800-925-9126 or 512-335-5986 to access this service.

Eligibility and claim status information is available on AIS twenty-three (23) hours a day, seven (7) days a week, with scheduled down time between 3:00 am – 4:00 am, Central Time. All other AIS information is available from 7:00 am – 7:00 pm, Central Time, Monday through Friday. AIS offers fifteen (15) transactions per call.

TexMedConnect

TexMedConnect is a free, web-based claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals and download ER&S Reports using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. Providers can use TexMedConnect on the TMHP website at tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx.

MEDICAID (STAR) MEMBER ENROLLMENT AND ELIGIBILITY

Enrollment

Texas Health and Human Services Commission (HHSC) in coordination with the state's Enrollment Broker, Maximus, administers the enrollment process for Medicaid (STAR) eligible individuals. Medicaid clients who are eligible for STAR choose a Managed Care Plan and a Primary Care Provider (PCP) using the official state enrollment form or by calling the Enrollment Broker. The date that a Medicaid (STAR) client becomes eligible for Medicaid (STAR) and the effective date of enrollment with the Managed Care Plan are not the same. Texas HHSC will make the final determination regarding Medicaid eligibility.

The Enrollment Broker can be contacted at the Medicaid Managed Care help line at 1-800-964-2777.

Newborn Enrollment

In the STAR Program, newborns are automatically assigned to the managed care plan the mother is enrolled with at the time of the newborn's birth for a period of at least ninety (90) days. The mother's plan will help her choose a PCP for the newborn prior to

SECTION III. MEMBER ELIGIBILITY AND ENROLLMENT

birth or as soon as possible after the birth. Once a Medicaid eligible baby's birth is reported, Texas HHSC will issue the newborn a Medicaid ID number.

All newborns remaining in the hospital after the mother's discharge, or admitted to Level 2 nursery or higher, must have an authorization for inpatient care. Call Texas Children's Health Plan's Utilization Management at 832-828-1004, option three (3) immediately for authorizations.

Automatic Re-Enrollment

If a member loses Medicaid eligibility but becomes eligible again within six (6) months or less, the member will automatically be enrolled in the same health plan the member was enrolled in prior to losing their Medicaid eligibility or the member may choose to switch health plans. The member will also be re-enrolled with the same PCP as they had before if they pick the same health plan, as long as that PCP is still in the Texas Children's Health Plan network.

Disenrollment

A member may request disenrollment from Texas Children's Health Plan. Any request from a member for disenrollment from Texas Children's Health Plan will require medical documentation from their PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHSC will make the final decision regarding eligibility, enrollment, disenrollment and automatic re-enrollment. Providers cannot take retaliatory action against members when a member is disenrolled from a managed care plan or from a provider's panel.

Disenrollment by Texas Children's Health Plan

Texas Children's Health Plan has a limited right to request a member be disenrolled from the health plan without the member's consent. Texas HHSC must approve the request for disenrollment of a member for cause. Texas Children's Health Plan will take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable documented measures may include providing education and counseling regarding the offensive acts or behaviors. Texas HHSC may permit disenrollment of a member under the following circumstances:

- Member misuses or loans their managed care ID card to another person to obtain services.
- Member's behavior is disruptive, unruly, threatening or uncooperative to the extent that

the member seriously impairs the provider's ability to provide services to the member, or to other patients, and the member's behavior is not caused by a physical or behavioral health condition.

- Member refuses to comply with managed care guidelines, such as repeated emergency room use, combined with refusal to allow the provider to treat the underlying medical condition or using a provider that is not in network.

Texas Children's Health Plan will work with a member before asking them to leave the plan. Texas HHSC will make the final determination.

Member Removal from a Provider Panel

Providers may request that a member be removed from their panel for the following reasons:

- Member gives their Texas Children's Health Plan ID card to another person for the purpose of obtaining services.
- Member continually disregards the advice of their PCP.
- Member repeatedly uses the emergency room in an inappropriate fashion.

The request to remove a member from a provider panel must be in writing and sent to Texas Children's Health Plan's Provider Relations Department. Please use the Physician Request for Removal of Member From Panel form located on our website at [texaschildrenshealthplan.org/for-providers/resources/downloadable-forms](https://www.texaschildrenshealthplan.org/for-providers/resources/downloadable-forms) under "Physician Requests." The completed form should be faxed to 832-825-8750. Providers may contact Texas Children's Health Plan at 832-828-1004 with questions regarding this process.

Pregnant Women and Infants

The Medicaid Enrollment Broker, Maximus, processes applications for pregnant women within fifteen (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. Pregnant women, including pregnant teens, may be retroactively enrolled in the STAR program based on their date of eligibility.

Newborns are covered under their mother's health plan for at least ninety (90) days following the date of birth, unless the mother requests a change. The mother can ask for a health plan change before the ninety (90) days expired by calling the Enrollment Broker.

Mothers are encouraged to contact the Enrollment

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Broker to enroll the newborn in the STAR program. Mothers are also encouraged to select a PCP for the newborn prior to birth. PCP selections can be done by calling Texas Children's Health Plan's Member Services at 832-828-1001 or toll-free at 1-866-959-2555.

Pregnant Teens

Providers are required to contact Texas Children's Health Plan immediately when a STAR teen member becomes pregnant. Call Texas Children's Health Plan's Member Services at 832-828-1001 to notify our Care Coordination Team to begin member outreach and education.

Health Plan Changes

Medicaid (STAR) clients have the right to change plans. Clients must call the Enrollment Broker, Maximus, at 1-800-964-2777 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Members can change health plans by calling the Texas Medicaid Managed Care help line at 1-800-964-2777.

STAR Member Rights and Responsibilities

Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care provider.
 - d. Change your health plan without penalty.
 - e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - 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.

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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, External Medical Reviews and State 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 an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
 - e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive 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:

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- 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.

Additional Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

CHIP AND CHIP PERINATE NEWBORN MEMBER ENROLLMENT AND ELIGIBILITY

Enrollment

Texas Health and Human Services Commission (HHSC) determines CHIP eligibility and will enroll and disenroll eligible individuals into and out of the CHIP program.

To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident.
- A Texas resident.
- Under the age of nineteen (19).
- Uninsured for at least ninety (90) days.
- Living in a family whose income is at or below 201% the Federal Poverty Level (FPL).

If a child is determined CHIP eligible, the Enrollment Broker, Maximus, sends the family an enrollment packet, which provides information about their health plan choices and any applicable enrollment fee. The family returns to the Enrollment Broker the completed enrollment forms and any applicable enrollment fee owed, and the Enrollment Broker processes the forms and enrolls the child in a health plan.

A CHIP member is enrolled for a period of twelve (12) months from the date the member is first covered by the plan. Enrollment in CHIP will begin on the first day of the month after eligibility is determined. Retroactive enrollment in CHIP would be determined by Texas HHSC.

Reenrollment

Two (2) months before the end of the twelve (12) month term of coverage, families are sent a renewal notice informing them that they must renew CHIP coverage. If a CHIP member does not reenroll within the specified time frame they will be disenrolled and will not be eligible until the month after their enrollment paperwork is received and renewal has been approved.

Disenrollment

Disenrollment may happen if a member is no longer eligible for CHIP. A member may lose CHIP eligibility if:

- A member turns nineteen (19).
- A member does not re-enroll by the end of the twelve (12) month coverage period.
- A member does not pay premium when due or within the grace period.

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- A member is covered under another health plan through an employer.
- Death of a member.
- A member moves out of the state.
- A member is enrolled in Medicaid.

Providers may not take retaliatory action against a CHIP member due to disenrollment.

If a CHIP member's effective date of coverage occurs while the member is confined in a hospital, the Managed Care Organization is responsible for the member's costs of covered services beginning on the effective date of coverage. If a member is disenrolled while the member is confined in a hospital, the Managed Care Organization's responsibility for the member's costs of covered services terminates on the date of disenrollment.

Health Plan Changes

CHIP members are allowed to make health plan changes under the following circumstances:

- For any reason within ninety (90) days of enrollment in CHIP.
- For cause at any time.
- If the client moves to a different service delivery area.
- During the annual re-enrollment period.

Texas HHSC will make the final decision.

CHIP Member Eligibility

- Twelve (12) month eligibility for CHIP members.
- A CHIP Perinate member 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 twelve (12) months of continuous coverage (effective on the date of birth) after the birth is reported to Texas 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 Texas HHSC's enrollment broker.
- A CHIP Perinate will continue to receive coverage through CHIP as a "CHIP Perinate Newborn" if born to a family with an income above Medicaid

Eligibility Threshold and the birth is reported to Texas HHSC's enrollment broker.

- A CHIP Perinate Newborn is eligible for twelve (12) months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven (11) months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinate health plan.
- Determination by the Administrative Services Contractor.

Pregnant Teens

Providers are required to contact Texas Children's Health Plan immediately when a pregnant CHIP member is identified, as most pregnant CHIP teenagers and their newborns may qualify for Medicaid. Call Texas Children's Health Plan's Member Services at 832-828-1002. The member will be referred to Texas HHSC, who will in turn evaluate eligibility for Medicaid and provide appropriate resource information. Those CHIP members who are determined to be Medicaid eligible will be disenrolled from Texas Children's Health Plan's CHIP plan.

CHIP and 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. "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

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- 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.

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.

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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.

CHIP PERINATE MEMBER ENROLLMENT AND ELIGIBILITY

The CHIP Perinate program, a subprogram of CHIP, is for unborn children of women who are not eligible for Medicaid. This benefit allows pregnant women who are ineligible for Medicaid due to income (whose income is greater than the Medicaid eligibility threshold) or immigration status (and whose income is also below the Medicaid eligibility threshold) to receive prenatal care for their unborn children. Upon delivery, newborns in families with income at or below the Medicaid eligibility threshold move from the CHIP Perinate program to Medicaid, where they receive twelve (12) months of continuous Medicaid coverage. CHIP Perinate Newborns in families with incomes above the Medicaid eligibility threshold remain in the CHIP Perinate program and receive CHIP benefits for a twelve (12) month coverage period, beginning on the date of enrollment as an unborn child (month of enrollment as an unborn child plus eleven (11) months).

CHIP Perinate members are exempt from the ninety (90) day waiting period, the asset test and all cost-sharing that applies to traditional CHIP members, including enrollment fees and copays for the duration of their coverage period.

Enrollment

Texas Health and Human Services Commission (HHSC) determines CHIP eligibility and makes the final decision of enrollment for all CHIP members. The mother of the CHIP Perinate has fifteen (15) calendar days from the time the enrollment packet is sent by the Enrollment Broker to enroll in a health plan. If a health

plan is not selected within fifteen (15) calendar days of the member receiving their enrollment packet, an automatic assignment will be made.

Newborn Process

When a member of a household enrolls in CHIP Perinate, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinate member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinate member's enrollment period, or (2) the end of the traditional CHIP members' enrollment period. Copayments, cost-sharing and enrollment fees still apply to children enrolled in CHIP.

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 members' information. Once the child's CHIP Perinate coverage expires, the child will be added to his or her siblings' existing CHIP case.

Disenrollment

Texas HHSC makes the final decision of disenrollment for all CHIP members. Disenrollment may happen if a member is no longer eligible for CHIP. A member may lose CHIP eligibility if:

- A member turns nineteen (19).
- A member does not re-enroll by the end of the twelve (12) month coverage period.
- A member does not pay premium when due or within the grace period.
- A member is covered under another health plan through an employer.
- Death of a member.
- A member moves out of the state.
- A member is enrolled in Medicaid.

Providers may not take retaliatory action against a CHIP member due to disenrollment.

Plan Changes

A CHIP Perinate member 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 twelve (12) months of continuous Medicaid coverage (effective on the date of birth) after the birth is

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reported to Texas 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 Texas HHSC's Enrollment Broker.

A CHIP Perinate will continue to receive coverage through CHIP as a "CHIP Perinate Newborn" if born to a family with an income above Medicaid eligibility threshold and the birth is reported to Texas HHSC's Enrollment Broker.

A CHIP Perinate Newborn is eligible for twelve (12) months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven (11) months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinate health plan.

CHIP Perinate mothers must select an MCO within fifteen (15) calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has ninety (90) days to select another MCO.

When a member of a household enrolls in CHIP Perinate, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinate member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinate member's enrollment period, or (2) the end of the traditional CHIP members' enrollment 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 members' information. Once the child's CHIP Perinate coverage expires, the child will be added to his or her siblings' existing CHIP case.

If a CHIP Perinate member's effective date of coverage occurs while the member is confined in a hospital, the MCO is responsible for the member's costs of covered services beginning on the effective date of coverage. If a member is disenrolled while the member is confined

in a hospital, the MCO's responsibility for the member's costs of covered services terminates on the date of disenrollment.

CHIP Perinate members may request to change health plans under the following circumstances:

- For any reason within ninety (90) days of enrollment in CHIP Perinate;
- If the member moves into a different service delivery area; and
- For cause at any time.

Eligibility Verification

Upon delivery, newborns in families with income at or below the Medicaid eligibility threshold move from the CHIP Perinate program to Medicaid, where they receive twelve (12) months of continuous Medicaid coverage. Continuous Medicaid coverage for twelve (12) months is provided from birth to CHIP Perinate Newborns whose mothers received Emergency Medicaid for the labor and delivery. The twelve (12) months of continuous Medicaid coverage for the newborn is available only if the mother received Medicaid for labor and delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinate-Emergency Medical Services Certification, Form H3038P, for the mother's labor with delivery. If Form H3038 or H3038P is not submitted, Medicaid cannot be established for the newborn from the date of birth for twelve (12) continuous months of Medicaid coverage. Establishing Medicaid (and issuance of a Medicaid number) can take up to forty-five (45) days after Form H3038 or H3038P is submitted. Medicaid eligibility for the mother and infant can be verified on the TMHP website at tmhp.com or by calling the Automated Inquiry System (AIS) at 1-800-925-9126 or 512-335-5986.

CHIP Perinate Newborns in families with incomes above the Medicaid eligibility threshold remain in the CHIP Perinate program and receive CHIP benefits for a twelve (12) month coverage period, beginning on the date of enrollment as an unborn child (month of enrollment as an unborn child plus eleven (11) months). CHIP benefit and eligibility information can be obtained by contacting the CHIP health plan.

SECTION III. MEMBER ELIGIBILITY AND ENROLLMENT

CHIP Perinate 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.

SECTION IV. COVERED SERVICES

Texas Children's Health Plan is required to provide specific, medically necessary services to its STAR and CHIP members. Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions.

Texas Children's Health Plan will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in STAR or CHIP programs.

MEMBER HANDBOOK

Every Texas Children's Health Plan STAR and CHIP member receives a member handbook when enrolled in Texas Children's Health Plan. Each handbook includes information about Texas Children's Health Plan that the member needs to know, including benefits. A copy of each Texas Children's Health Plan member handbook can be accessed through Texas Children's Health Plan's website at texaschildrenshealthplan.org/for-members.

SPELL OF ILLNESS AND ANNUAL MAXIMUM LIMITATION

Traditional Medicaid and CHIP programs define the Spell of Illness Limitation as thirty (30) days of inpatient hospital care, which may accrue intermittently or consecutively. After thirty (30) days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for sixty (60) consecutive days. This limitation does not apply to Texas Children's Health Plan STAR or CHIP members.

For STAR and CHIP members with Texas Children's Health Plan, the \$200,000 annual limit on inpatient services does not apply.

COORDINATION WITH OTHER STATE PROGRAM SERVICES

Coordination with Public Health

Texas Children's Health Plan is required to coordinate with public health entities regarding the provision of services for essential public health services. Providers must assist Texas Children's Health Plan 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 notification or referral to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving members.

- Reporting to the local Public Health Entity for Tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons with whom the member has come into contact.
- Reporting to the local Public Health Entity for Sexually Transmitted Disease (STD)/ Human Immunodeficiency Virus (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 and information sharing.
- Reporting of immunizations provided to the statewide ImmTrac2 Registry at dshs.texas.gov/immunize/immtrac/default.shtm, including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment.

Coordination for Services Not Directly Provided Through Texas Children's Health Plan

There are several services that are available to Texas Children's Health Plan members based on their STAR or CHIP eligibility and are accessed outside of Texas Children's Health Plan's provider network. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM) and include the following:

- Texas Health Steps dental (including orthodontia).
- Texas Health Steps environmental lead investigation (ELI).
- Early Childhood Intervention (ECI) case management/service coordination.
- Early Childhood Intervention Specialized Skills Training.
- Texas School Health and Related Services (SHARS) – Medicaid only.
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program.
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- Texas HHSC hospice services.
- Admissions to inpatient mental health facilities as a condition of probation.

SECTION IV. COVERED SERVICES

- Texas Health Steps Personal Care Services for members birth through age twenty (20) – Medicaid only.

Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services Commission for families with children birth up to age 3, with developmental delays, disabilities or certain medical diagnoses that may impact development. ECI services support families as they learn how to help their children grow and learn.

Texas Children's Health Plan strongly encourages providers to identify and provide ECI referral information to the legally authorized representative or LAR for members under the age of three years old suspected of having a developmental delay or disability or otherwise meeting the eligibility criteria for ECI services. Texas Children's also accepts self-referrals to the local ECI providers without a referral from the members PCP. For information on the qualifications and referral form visit this website <https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services>.

All network providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Texas Children's Health Plan's Care Coordination Department at 1-832-828-1008, option eight (8).

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

Veyo provides transportation to covered health care services for Texas Children's Health Plan Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. Veyo services do not include ambulance trips.

Transportation services offered by Texas Children's Health Plan:

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual

transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.

- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a covered health care service. The daily rate for meals is \$25 per day for the member and \$25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

Members needing assistance with traveling to and from their appointment, Texas Children's Health Plan will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving Texas Children's Health Plan's transportation Services, please refer him or her to Veyo at 1-888-401-0170 for more information.

Requesting NEMT Services

Nonemergency Medical Transportation Services can be arranged by Members calling 1-888-401-0170 to request a ride.

In order to schedule with Veyo Members will need to provide:

- Name, Member ID, Date of Birth, and/ or eligibility address to verify eligibility of service

SECTION IV. COVERED SERVICES

- Logistics of trip (will they have a guardian/ attendant, language needs, COVID screening procedure, do they need a wheelchair accessible ride, etc.)
- Members scheduling transportation for health-related services within their Service Area will need to schedule rides with a two-business day notice. For members looking to go outside of that service area, they must give at least a five-business day notice.
 - Note this constraint does not apply if members need access to treatment for an “urgent condition” such as getting home after a hospital discharge, or going to the pharmacy

MEMBER’S RIGHT TO DESIGNATE AN OB/GYN

Attention Female Members

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

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

Pregnant Members

Providers are required to contact Texas Children’s Health Plan immediately when a pregnant STAR or CHIP member is identified. Call Texas Children’s Health Plan’s Member Services at 832-828-1001 (STAR) or 832-828-1002 (CHIP).

ACCESS TO SPECIALISTS

Texas Children’s Health Plan does not require authorization or referrals from primary care providers to see a network specialist.

INPATIENT HOSPITALIZATIONS

Texas Children’s Health Plan will authorize medically necessary care for qualifying members at out-of-network facilities only until stabilization of the member. Upon stabilization, failure to transfer qualifying members will result in authorization denial and claims denials for subsequent days. The transferring facility should make all attempts to transfer our members to an in-network facility after confirming the accepting facility is capable of rendering the required level of care.

MEDICAID (STAR) COVERED SERVICES

Texas Children’s Health Plan’s Medicaid (STAR) members receive all the benefits of the traditional Texas Medicaid program. Medicaid (STAR) benefits include, but may not be limited to:

- Emergency and non-emergency ambulance services.
- Audiology services, including hearing aids.
- Behavioral health services, including:
 - Inpatient mental health services for children (birth through age twenty (20)).
 - Acute inpatient mental health services for adults.
 - Outpatient mental health services.
 - Psychiatry services.
 - Mental health rehabilitative services.
 - Counseling services for adults (twenty-one (21) years of age and over).
 - Outpatient substance use disorder treatment services including:
 - Assessment.
 - Detoxification services.
 - Counseling treatment.
 - Medication assisted therapy.
 - Residential substance use disorder treatment services including:
 - Detoxification services
 - Substance use disorder treatment (including room and board)
- Birthing services provided by a licensed birthing center.
- Birthing services provided by a physician or advanced practice nurse in a licensed birthing center.
- Cancer screening, diagnostic and treatment services.
- Chiropractic services.
- Dialysis.
- Durable medical equipment and supplies.
- Emergency services.
- Family planning services.
- Home health care services.
- Hospital services, including inpatient and

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- outpatient.
- Immunizations.
- Laboratory.
- Mastectomy, breast reconstruction and related follow up procedures including:
 - Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient or outpatient setting for all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
 - Surgery and reconstruction on the other breast to produce symmetrical appearance.
 - Treatment of physical complications from the mastectomy and treatment of lymphedema; prophylactic mastectomy to prevent the development of breast cancer.
 - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) services for children, adolescents and young adults (birth through age twenty (20)) through the Texas Health Steps Program.
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkups for children six (6) months of age.
- Podiatry.
- Prenatal care.
- Prescription drugs.
- Primary care services.
- Preventive service, including an annual adult well check for patients twenty-one (21) years of age and over.
- Radiology, imaging and X-rays.
- Specialty physician services.
- Therapies – physical, occupational and speech.
- Transplantation of organs and tissues.
- Vision (includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which cannot be accomplished by glasses).

- Telemedicine
- Telemonitoring
- Telehealth

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Texas Children's Health Plan member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Centers (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 member 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 member's medical condition or the authorized hours are not commensurate with the member's medical needs. Per 1 Tex. Admin. Code §363.209 (c) (3), PPECC services are intended to be a one-to-one replacement of PDN hours, unless additional hours are medically necessary.

Family Planning Services

Family Planning Services, including sterilization, are covered STAR member benefits and do not require prior authorization. These services can be provided by an in-network provider for Texas Children's Health Plan. 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.

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Sterilization services are a benefit. In the event that a Texas Children's Health Plan member aged twenty-one (21) years or older chooses sterilization, providers must use the current state-approved sterilization consent form and complete at least thirty (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 tmhp.com by clicking on the Family Planning link under the Provider section.

Family Planning Program

Health and Human Services Family Planning Program assists with funding clinic sites across Texas to provide quality, comprehensive, low-cost and accessible family planning and reproductive healthcare services to women and men. The available services help people plan the number and spacing of their children, reduce unintended pregnancies, improve future pregnancy and birth outcomes and improve overall health. The Family Planning Program priority is to emphasize the importance of counseling family planning clients on establishing a reproductive life plan, and providing preconception counseling as a part of family planning services, as appropriate.

Preconception care seeks to identify patients with risk factors (such as overweight/obesity, diabetes, low folic acid intake, smoking or alcohol use, etc.) that must be addressed before conception in order to prevent fertility problems and reduce health problems of the mother and baby. The main goal of preconception care is to provide health promotion, counseling, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies.

Source: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/family-planning>

Provider resources on this program are available here, <https://www.healthytexaswomen.org/provider-resources/family-planning-program-provider-resources>

Primary Health Care Services Program

Family Planning services are available through this program by working with clinic sites so eligible residents have access to comprehensive primary care services. Additional services include the following:

- Health education
- Emergency services

- Diagnosis and treatment
- Diagnostic testing, such as X-rays and lab services
- Preventive health services, including immunizations

For more information on the Primary Health Care Services Program visit <https://www.hhs.texas.gov/services/health/primary-health-care-services-program>

Additional Benefits

STAR members who are twenty-one (21) years of age or older receive unlimited medically necessary prescription drugs. The elimination of the three (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.

An annual adult physical exam performed by a member's Primary Care Provider is an additional benefit of the STAR program for members twenty-one (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.

Value Added Services

Value added services are extra health care benefits offered by Texas Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services can be found on our website at texaschildrenshealthplan.org/what-we-offer/extra-benefits.

CHIP AND CHIP PERINATE NEWBORN COVERED SERVICES

Texas Children's Health Plan is required to provide specific medically necessary services to its CHIP and CHIP Perinate Newborn members. Covered services for CHIP and CHIP Perinate Newborn members must meet the CHIP definition of "medically necessary." Medically necessary health services means:

- Non-behavioral health services that are:
 - reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member or endanger life;

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- 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 member’s diagnoses;
 - no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency;
 - not experimental or investigative; and
 - 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;
 - are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - are the most appropriate level or supply of service that can be safely provided;
 - could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered;
 - are not experimental or investigative; and
 - are not primarily for the convenience of the member or provider.

annual cost-sharing maximum. Some CHIP members might have additional group or individual coverage available to them. When this occurs, Texas Children’s Health Plan will coordinate benefits as the secondary insurance payer.

There is no lifetime maximum on benefits; however, a twelve (12) month enrollment period or lifetime limitations do apply to certain services, as specified in the following pages. Texas Children’s Health Plan will not impose any pre-existing condition limitations or exclusions to CHIP-eligible members.

Some members may have copayments and in this case, copayments apply until the member reaches their

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CHIP and CHIP Perinate Newborn Benefits and Cost Sharing

The following information is the benefits table for CHIP and CHIP Perinate Newborn members.

Type of Benefit	Description of Benefit	Copay
Inpatient General Acute and Inpatient Rehabilitation	<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 forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care. 	Applicable level of inpatient copay applies.

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Type of Benefit	Description of Benefit	Copay
Inpatient General Acute and Inpatient Rehabilitation	<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.• Surgical implants.• Other artificial aids including surgical implants.• Inpatient services for a mastectomy and breast reconstruction, including:<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 twelve (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 syndromal conditions and/or tumor growth or its treatment.	Applicable level of inpatient copay applies.

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Type of Benefit	Description of Benefit	Copay
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>Copays do not apply.</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. • 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: <ul style="list-style-type: none"> – dilation and curettage (D&C) procedures; – appropriate provider-administered medications; – ultrasounds; and – histological examination of tissue samples. 	<ul style="list-style-type: none"> • Applicable level of copay applies to prescription drug services. • Copays do not apply to preventive services or outpatient services.

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Type of Benefit	Description of Benefit	Copay
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center</p>	<ul style="list-style-type: none"> • 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, including: <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 twelve (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 syndromal conditions and/or tumor growth or its treatment. 	<ul style="list-style-type: none"> • Applicable level of copay applies to prescription drug services. • Copays do not apply to preventive services or outpatient services.

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Type of Benefit	Description of Benefit	Copay
Physician/ Physician Extender Professional Services	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – 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; and – 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, including: <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. 	<ul style="list-style-type: none"> • Applicable level of copay applies to office visits. • Copays do not apply to preventive services.

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Type of Benefit	Description of Benefit	Copay
Physician/ Physician Extender Professional Services	<ul style="list-style-type: none"> • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (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: <ul style="list-style-type: none"> – dilation and curettage (D&C) procedures; – appropriate provider-administered medications; – 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: <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 syndromal conditions and/or tumor growth or its treatment. 	<ul style="list-style-type: none"> • Applicable level of copay applies to office visits. • Copays do not apply to preventive services.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	<ul style="list-style-type: none"> • Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. 	Copays do not apply.

SECTION IV. COVERED SERVICES

Type of Benefit	Description of Benefit	Copay
Birthing Center Services	Covers birthing services provided by a licensed birthing center.	None
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	<ul style="list-style-type: none"> • Covers prenatal services and birthing services rendered in a licensed birthing center. • CHIP Perinate Newborn members: Covers services rendered to a newborn immediately following delivery. 	None
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	<p>\$20,000 twelve (12) month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which 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:</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. 	Copays do not apply.

SECTION IV. COVERED SERVICES

Type of Benefit	Description of Benefit	Copay
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 (R.N., L.V.N.). • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • 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 an intermittent level and not intended to provide twenty-four (24) hour skilled nursing services. • Services are not intended to replace twenty-four (24) hour inpatient or skilled nursing facility services. 	Copays do not apply.
Inpatient Mental Health Services	<p>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:</p> <ul style="list-style-type: none"> • 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 PCP referral. 	Applicable level of inpatient copay applies.

SECTION IV. COVERED SERVICES

Type of Benefit	Description of Benefit	Copay
Outpatient Mental Health Services	<p>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> • Neuropsychological and psychological testing (visits can be furnished in a variety of community-based settings [including school and home-based] or in a state-operated facility). • 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 (which can be components of interventions such as day treatment and in-home services), patient and family education and crisis services. • Does not require PCP referral. 	<p>Applicable level of copay applies to office visits.</p>

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Type of Benefit	Description of Benefit	Copay
Inpatient Substance Use Disorder Treatment Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and twenty-four (24) hour residential rehabilitation programs. • Does not require PCP referral. 	Applicable level of copay applies to office visits.
Outpatient Substance Use Disorder 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 are defined as organized nonresidential services providing structured group and individual therapy, educational services and life skills training which consist of at least ten (10) hours per week for four to twelve (12) weeks, but less than twenty-four (24) hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services and life skills training. • Does not require PCP referral. 	Applicable level of copay applies to office visits.
Rehabilitation Services	<p>Services include, but are not limited to, the following:</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. 	Copays do not apply.

SECTION IV. COVERED SERVICES

Type of Benefit	Description of Benefit	Copay
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 six (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. • Up to a maximum of 120 days with a six (6) month life expectancy. • Patients electing hospice services may cancel this election at anytime. • Services apply to the hospice diagnosis. 	Copays do not apply.
Emergency Services, including Emergency Hospitals, Physicians and Ambulance Services	<p>Health plan does not require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent layperson definition of emergency health condition. • Hospital emergency department room and ancillary services and physician services twenty-four (24) hours a day, seven (7) days a week, both by in-network and out-of-network providers. • Medical screening examination. • Stabilization services. • Access to DSHS designated Level I 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, removal of cysts and treatment relating to oral abscess of tooth or gum origin. 	Applicable copays apply to emergency room visits (facility only).
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. 	Copays do not apply.

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Type of Benefit	Description of Benefit	Copay
Vision Benefit	<p>Health plan may reasonably limit the cost of the frames/lenses. Services include:</p> <ul style="list-style-type: none"> • One (1) examination of the eyes to determine the need for and prescription for corrective lenses per twelve (12) month period, without authorization. • One (1) pair of non-prosthetic eyewear per twelve (12) month period. 	Applicable level of copay applies to office visits billed for refractive exam.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Applicable level of copay applies to chiropractic office visits.
Tobacco Cessation Program	<p>Covered up to \$100 for a twelve (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. 	Copays do not apply.
Case Management and Care Coordination Services	These services include outreach, case management, care coordination and community referral.	Copays do not apply.
Drug Benefits	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals, including pharmacy dispensed and provider-administered outpatient drugs and biologicals. • Drugs and biologicals provided in an inpatient setting. 	Applicable level of copay applies for pharmacy dispensed drug benefits.

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CHIP and CHIP Perinate Newborn Exclusions from Covered Services

The following services, supplies, procedures and expenses are not benefits of the CHIP and CHIP Perinate Newborn program:

- 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 forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (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.

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- Charges incurred as a donor of an organ when the recipient is not covered under Texas Children's 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).

CHIP and CHIP Perinate Newborn DME and Supplies

Note: DME supplies are not a covered benefit for CHIP Perinate members, with the exception of a limited set of disposable medical supplies, published at txvendordrug.com/formulary/formulary/home-health-supplies, when they are obtained from an authorized pharmacy provider.

Supplies	Covered	Excluded	Comments/ Member Contract Provisions
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency, it is covered as an incidental supply.
Alcohol, Rubbing		X	Over-the-counter supply.
Alcohol, Swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, Swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age four (4) or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.

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Supplies	Covered	Excluded	Comments/ Member Contract Provisions
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age four (4) or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment and tape. Many times these items are dispensed in a kit which includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/ Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.

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Supplies	Covered	Excluded	Comments/ Member Contract Provisions
Formula		X	<p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel or malabsorption due to disease (expected to last longer than sixty (60) days when prescribed by the physician and authorized by health plan) physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> • Identification of a metabolic disorder • Dysphagia that results in a medical need for a liquid diet • Presence of a gastrostomy, or • Disease resulting in malabsorption that requires a medically necessary nutritional product <p>Does not include formula:</p> <ul style="list-style-type: none"> • For members who could be sustained on an age-appropriate diet • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than fifty (50) percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight or lack of growth or for infants less than twelve (12) months of age unless medical necessity is documented and other criteria, listed above, are met <p>Food thickeners, baby food or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	<p>Exception: Central line dressings or wound care provided by home care agency.</p>

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Supplies	Covered	Excluded	Comments/ Member Contract Provisions
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age four (4) or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/ Diabetic			See Diabetic Supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/ Central Line.
Needles and Syringes/ Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		<p>Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover and pouch deodorant.</p> <p>Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps and lotions.</p>

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Supplies	Covered	Excluded	Comments/ Member Contract Provisions
Parenteral Nutrition/ Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when health plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: <ul style="list-style-type: none"> • when used to dilute medications for nebulizer treatments • as part of covered home care for wound care • for indwelling urinary catheter irrigation
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, tubes, ties, holders, cleaning kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter and Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the Primary Care Provider and approved by health plan.
Urinary, Indwelling Catheter and Supplies	X		Covers catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Covers supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

SECTION IV. COVERED SERVICES

CHIP Copay Requirements

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.

There are no copayments for preventive care, such as immunizations, well-child or well-baby visits. The member's Texas Children's Health Plan ID card lists the copayment requirements that apply to their family situation. Members should present their ID card at each office visit, emergency room visit or when a prescription is filled.

CHIP Perinate and CHIP Perinate Newborn members do not have any copay requirements.

Federal Poverty Level (FPL)	Office Visits (Non-preventive)	Non-Emergency ER	Facility Copay, Inpatient (Per admission)	Generic Drugs	Brand Drugs	Cost-sharing Cap
Native Americans (CHNA)	\$0	\$0	\$0	\$0	\$0	\$0
At or below 100% (CHIP)	\$3	\$3	\$15	\$0	\$3	5% of family income*
Above 100% up to and including 151% (CHIP 1)	\$5	\$5	\$35	\$0	\$5	5% of family income*
Above 151% up to and including 186% (CHIP 2)	\$20	\$75	\$75	\$10	\$35	5% of family income*
Above 186% up to and including 201% (CHIP 3)	\$25	\$75	\$125	\$10	\$35	5% of family income*

* Per 12-month term of coverage

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Additional Benefits

There is no Spell of Illness Limitation for CHIP and CHIP Perinate Newborn members. The Spell of Illness limitation is defined as thirty (30) days of inpatient hospital care, which may accrue intermittently or consecutively. After thirty (30) days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for sixty (60) consecutive days.

Value Added Benefits

Value added services are extra health care benefits offered by Texas Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services can be found on our website at texaschildrenshealthplan.org/what-we-offer/extra-benefits

CHIP PERINATE COVERED SERVICES

Covered CHIP Perinate services must meet the definition of medically necessary covered services. There is no lifetime maximum on benefits; however, a twelve (12) month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Copays do not apply to CHIP Perinate members. CHIP Perinate Newborn members are eligible for twelve (12) months continuous coverage, beginning with the month of enrollment as a CHIP Perinate.

A newborn born to a perinatal mother whose financial status is at or below the Medicaid eligibility threshold may be enrolled in Medicaid if he or she qualifies.

Babies born to perinatal mothers who are above the Medicaid eligibility threshold will be enrolled with Texas Children's Health Plan as a CHIP Perinate Newborn. The newborn's CHIP Perinate Newborn continues for twelve (12) months from the date of the mother's initial CHIP Perinate enrollment.

CHIP Perinate Benefits

The following information is the benefits table for CHIP Perinate members (unborn child).

Type of Benefit	Description of Benefit
Inpatient General Acute and Inpatient Rehabilitation	<p>For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), 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)• 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).• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit. 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;

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Type of Benefit	Description of Benefit
Inpatient General Acute and Inpatient Rehabilitation	<ul style="list-style-type: none">– appropriate provider-administered medications;– ultrasounds; and– histological examination of tissue samples.
Birthing Center Services	<ul style="list-style-type: none">• Applies only to CHIP Perinate members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).• Covers birthing services provided by a licensed birthing center.• Limited to facility services related to labor with delivery.
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	<p>Covers prenatal services, birthing services and services rendered to a newborn immediately following delivery in a licensed birthing center.</p> <p>Prenatal services subject to the following limitations:</p> <ul style="list-style-type: none">• Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:<ol style="list-style-type: none">1. One (1) visit every four (4) weeks for the first twenty-eight (28) weeks of pregnancy;2. One (1) visit every two (2) to three (3) weeks from twenty-eight (28) to thirty-six (36) weeks of pregnancy; and3. One (1) visit per week from thirty-six (36) weeks to delivery. <p>More frequent visits are allowed as medically necessary. Benefits are limited to:</p> <ul style="list-style-type: none">• Limit of twenty (20) prenatal visits and two (2) postpartum visits (maximum within sixty (60) days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to twenty (20) visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none">• Interim history (problems, marital status, fetal status);• Physical examination (weight, blood pressure, 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 thirty-two (32) to thirty-six (36) weeks of pregnancy, multiple marker screen for fetal abnormalities offered at sixteen (16) to twenty (20) weeks of pregnancy; repeat antibody screen for Rh negative women at twenty-eight (28) weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at twenty-four (24) to twenty-eight (28) weeks of pregnancy; and other lab tests as indicated by medical condition of client).

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Type of Benefit	Description of Benefit
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	<p>Services include, 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 nonviable 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:<ul style="list-style-type: none">– dilation and curettage (D&C) procedures;– appropriate provider administered medications;– ultrasounds; and– histological examination of tissue samples. <ol style="list-style-type: none">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 nonviable 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: non stress testing, contraction stress testing, hemoglobin or hematocrit repeated once a trimester and at thirty-two (32) to thirty-six (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 twenty-eight (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 sixteen (16) and twenty (20) weeks); screen for gestational diabetes at twenty-four (24) to twenty-eight (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 pregnancy or a fetus that expired in utero) are a covered benefit.

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Type of Benefit	Description of Benefit
Physician/Physician Extender Professional Services	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none">• 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:<ul style="list-style-type: none">– 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; and– 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-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:<ul style="list-style-type: none">– dilation and curettage (D&C) procedures;– appropriate provider administered medications;– ultrasounds; and– histological examination of tissue samples.

SECTION IV. COVERED SERVICES

Type of Benefit	Description of Benefit
Prenatal Care and Pre-Pregnancy Family Services and Supplies	<p>Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <ol style="list-style-type: none">1. One (1) visit every four (4) weeks for the first twenty-eight (28) weeks of pregnancy;2. One (1) visit every two (2) to three (3) weeks from twenty-eight (28) to thirty-six (36) weeks of pregnancy; and3. One (1) visit per week from thirty-six (36) weeks to delivery. <p>More frequent visits are allowed as medically necessary. Benefits are limited to: Limit of twenty (20) prenatal visits and two (2) postpartum visits (maximum within sixty (60) days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to twenty (20) visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.</p> <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none">• 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 thirty-two (32) to thirty-six (36) weeks of pregnancy; multiple marker screen for fetal abnormalities offered at sixteen (16) to twenty (20) weeks of pregnancy; repeat antibody screen for Rh negative women at twenty-eight (28) weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at twenty-four (24) to twenty-eight (28) weeks of pregnancy; and other lab tests as indicated by medical condition of client).

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Type of Benefit	Description of Benefit
Emergency Services, including Emergency Hospitals, Physicians and Ambulance Services	<p>Texas Children's Health Plan does not require authorization as a condition for payment for emergency conditions related to labor with delivery. 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 layperson definition of emergency health condition.• 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.• Benefit limits:<ul style="list-style-type: none">– Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.– Evaluations for labor symptoms that do not result in delivery are not a covered benefit.
Case Management and Care Coordination Services	<p>Covered benefit - these services include outreach, case management, care coordination and community referral.</p>
Drug benefits	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none">• Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals.• Drugs and biologicals provided in an inpatient setting. <p>Services must be medically necessary for the unborn child.</p>
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	<p>Not a covered benefit (With the exception of a limited set of disposable medical supplies, published at https://www.txvendordrug.com/providers/pharmacy-enrollment-dme-provider and only when they are obtained from a CHIP-enrolled pharmacy provider.)</p>

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CHIP Perinate Exclusions from Covered Services

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), 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.
- Contraceptive medications and devices prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- 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.
- Durable medical equipment or other medically related remedial devices.
- Outpatient mental health services.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider.
- 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 postpartum 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.
- 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).
- 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.
- Medications prescribed for weight loss or gain.
- 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).

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- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- 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.

Value Added Benefits

Value added services are extra health care benefits offered by Texas Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services can be found on our website at texaschildrenshealthplan.org/what-we-offer/extra-benefits.

BREAST PUMP COVERAGE IN MEDICAID AND CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage & Billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

* CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

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HEALTHY TEXAS WOMEN PROGRAM

The Healthy Texas Women program offers women's health and family planning services to eligible, low-income women as a transition from the Medicaid for Pregnant Women program coverage. Eligible women will receive a letter from the Texas Health and Human Services confirming their enrollment in the Healthy Texas women program. If you have questions about a member's enrollment, call 2-1-1 or visit <https://www.healthytexaswomen.org>

The services help women plan their families, whether they want to achieve, postpone or prevent pregnancy. These services may also have a positive effect on future pregnancy planning and general health. Healthy Texas Women provides a wide variety of women's health and core family planning services, including:

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services
- Breast and cervical cancer screenings
- Clinical breast examination
- Mammograms
- Screening and treatment for cholesterol, diabetes and high blood pressure
- HIV screening
- Long-acting reversible contraceptives
- Oral contraceptive pills
- Permanent sterilization
- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections
- Screening and treatment for postpartum depression

Resources:

HTW Eligibility Information:

<https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women/htw-who-can-apply>

The Texas Long-Acting Reversible Contraception Toolkit:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/women/texas-larc-toolkit.pdf>

HEALTHY TEXAS WOMEN PLUS PROGRAM

Services for this program began September 1, 2020, and benefits become available after the first 60 days of the postpartum period, and for a period of not more than 12 months after the date of enrollment in HTW. The enhanced postpartum services package is called HTW Plus. Women in HTW Plus will have access to both HTW and HTW Plus benefits.

To qualify for HTW Plus benefits, HTW clients must have been pregnant within the last 12 months. HTW Plus services will focus on treating major health conditions recognized as contributing to maternal morbidity and mortality in Texas, including:

- Postpartum depression and other mental health conditions
 - Services include individual, family and group psychotherapy services; and peer specialist services.
- Cardiovascular and coronary conditions
 - Services include imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet, and antihypertensive medications.
- Substance use disorders, including drug, alcohol and tobacco use
 - Services include screening, brief intervention, and referral for treatment (SBIRT), outpatient substance use counseling, smoking cessation services, medication-assisted treatment (MAT), and peer specialist services.

For more information on the Healthy Texas Women Plus Program go to <https://www.tmhp.com/news/2020-08-28-healthy-texas-women-htw-plus-services-available-september-1-2020>

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

House Bill 133, 87th Legislature, Regular Session, 2021, requires the case management for children and pregnant women benefit to be carved-in to Medicaid managed care, which means Medicaid managed care organizations like Texas Children's Health Plan (TCHP) will need to contract with and reimburse providers for billable case management services.

Eligibility

This benefit is available for Medicaid-eligible:

- Children birth through age 20 with health condition or health risk; or

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- Pregnant women of any age who have a high-risk condition; and
- Need assistance in gaining access to medically necessary medical, social, educational, and other services related to the health condition, health risk or high-risk condition; and
- Want case management.

Highlights of the carve-in Medicaid benefit are as follows:

- A Medicaid State Plan benefit and a component of the Texas Health Steps service array
- Assists eligible clients in gaining access to medically necessary medical, social, educational and other services
- Provides health related case management services to Medicaid eligible children and pregnant women
- Existing prior authorizations must be honored to comply with current continuity of care requirements.

Eligible Provider Types to administer this benefit include the following:

- Registered nurses
- Licensed social workers
- May be self-employed or work for
 - Nonprofit agencies/organizations
 - Health-care clinics (including FQHC's)

All Case Management for Children and Pregnant Women Medicaid providers must:

- Receive approval from Health and Human Services Commission (HHSC), enroll with Texas Medicaid and HealthCare Partnership (TMHP) as a Medicaid provider, and bill TMHP directly for each service.
- Complete HHSC's standardized case management training.

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TEXAS HEALTH STEPS

The Texas Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis and treatment for Medicaid recipients from birth through twenty (20) years of age. In Texas, the EPSDT program is known as Texas Health Steps (THSteps), which includes the preventive care components, or Early and Periodic Screening, of the total EPSDT service.

Texas Children's Health Plan's goal is for new members to have a preventive health visit with a THSteps enrolled provider within ninety (90) days of enrollment, and for every existing member to have a preventive health visit in accordance with the periodicity guidelines.

BECOMING A TEXAS HEALTH STEPS PROVIDER

Providers performing medical, dental and case management services can become Texas Health Steps (THSteps) providers. You must be an enrolled THSteps provider in order to be reimbursed for THSteps services. Enrollment must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at tmhp.com. For enrollment assistance, please contact the TMHP Contact Center, 1-800-925-9126, option two (2), or send an email to Provider.Enrollment.Mailbox@tmhp.com to request assistance with enrollment questions.

MORE ABOUT TEXAS HEALTH STEPS

Additional details regarding the Texas Health Steps (THSteps) and Comprehensive Care program services, including private duty nursing, prescribed pediatric extended care centers and therapies can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Volume 2: Children's Services Handbook and in subsequent Medicaid bulletins at tmhp.com

Medical checkups must be performed in accordance with the THSteps medical checkups periodicity schedule that is based in part on the American Academy of Pediatrics (AAP) recommendations. Providers can find an updated THSteps periodicity schedule at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers>

MEDICAL CHECKUPS AND SCREENINGS

Texas Children's Health Plan encourages Primary Care Providers (PCPs) to perform the Texas Health Steps (THSteps) checkups; however, Texas Children's Health Plan will allow any network provider to perform the THSteps medical checkup and screening, as long as the individual is also recognized as a THSteps provider by Texas Health and Human Services Commission (HHSC). It is the responsibility of the PCP to ensure that these checkups are provided in their entirety and at the required intervals. Immunizations must be provided as part of the examination. Members may not be referred to local health departments to obtain immunizations.

If the PCP is not the provider performing the THSteps checkup, the performing provider must provide the PCP with a report regarding the screening. In addition, if the performing provider diagnoses a medical condition that requires additional treatment, the patient must be referred back to their PCP or a referral for further treatment must be obtained from the PCP.

Medical Checkup

All initial screenings are to be performed by the member's PCP or other network THSteps provider and include, at a minimum:

- Comprehensive health and developmental history that includes:
 - Nutritional assessment.
 - Developmental assessment, including 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 level assessments and other tests appropriate for age and risk).
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) immunization schedule.

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- Health education/anticipatory guidance.
- Referral services (e.g., CCP services, WIC, family planning and dental services). Providers must coordinate with the Special Supplemental Nutrition Program for women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin. For WIC eligibility requirements and other information visit texaswic.org

Sports physical exams do not qualify as THSteps checkups.

Performing Newborn Screenings

Newborn examinations must be provided prior to his or her discharge from the hospital. The THSteps medical checkups include, at a minimum:

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

Newborn Testing

Any provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns as required by Texas law. All infants must be tested a second time at one (1) to two (2) weeks of age. These tests must be submitted to the Department of State Health Services (DSHS) Laboratory Services Section. For complete information, instructions and newborn screening forms, visit dshs.texas.gov/lab/mrs_forms.shtm or contact:

Department of State Health Services
Newborn Screening Unit
512-776-3957
newborn@dshs.texas.gov

Performing Adolescent Screenings

Adolescent preventive screenings are covered under the THSteps medical program. An “adolescent preventive visit” is not considered an exception to periodicity. The adolescent screening visits are performed in addition to regular THSteps periodic checkups.

The protocol for performing these screens includes:

- Comprehensive/anticipatory health guidance for adolescents and their parents.
- Screening for specific conditions common to adolescents.
- Immunization to prevent selected infectious diseases.

Exceptions to Periodicity Allowed

On occasion, a child may require a THSteps checkup that is outside of the recommended schedule. Such reasons for an exception to periodicity include:

- Medical necessity (developmental delay, suspected abuse).
- Environmental high risk (for example, sibling of child with elevated lead blood level).
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption.
- Required for dental services provided under general anesthesia.

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the standard billing requirements as discussed in the Claims and Billing section of this Provider Manual.

If a provider other than the PCP performs the exception to periodicity medical checkup, the PCP must be provided with medical record information. In addition, all necessary follow-up care and treatment must be referred to the PCP.

TEXAS HEALTH STEPS ENVIRONMENTAL LEAD INVESTIGATION (ELI)

In accordance with current federal regulations, Texas Health Steps (THSteps) requires blood lead screening at the ages notated on the THSteps Periodicity Schedule and must be performed during the medical checkup. Effective June 22, 2021, initial blood lead testing performed in the office using point-of-care testing, procedure code 83655 with modifier QW, may be billed to a THSteps visit per guidance from TMPPM, Children Services Handbook, section 5.3.11.6.6. Providers must have a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver to perform this lab test in the office.

Reporting all blood lead levels is a law in Texas. For more information, <https://www.dshs.texas.gov/lead/Reporting-Laws-Administrative-Code.aspx>.

Providers may obtain more information about the

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medical and environmental management of lead poisoned children from the Department of State Health Services (DSHS) Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at dshs.texas.gov/elpl/.

LABORATORY TESTING

Laboratory specimen collection testing materials and necessary forms and supplies are made available free of charge to all Texas Health Steps (THSteps) providers. For forms and supplies, providers should contact the Department of State Health Services (DSHS) Laboratory Services Section at the phone number or website below:

Department of State Health Services
Laboratory Services Section
512-776-7318
dshs.texas.gov/lab/mrs_forms.shtm

Providers may not bill for supplies and services provided by the DSHS laboratory. Tests for hemoglobin/hematocrit, chlamydia, gonorrhea and lead must be sent to the DSHS lab, with the exception of point-of-care testing in the provider's office for the initial lead specimen. All other tests may be sent to Quest Diagnostics as our exclusive reference lab provider.

IMMUNIZATIONS

Children, adolescents and young adults must be immunized during medical checkups and, according to the Advisory Committee on Immunization Practices (ACIP) schedule, by age and immunizing agent. Texas Children's Health Plan requires the immunizations be done unless medically contraindicated or against parental beliefs.

Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac2) 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 eighteen (18) years of age (those eighteen (18) and older may now consent for their records to be maintained in ImmTrac2 as well). Provider must verify consent before information is included in ImmTrac2. If provider is unable to verify consent, the provider will be notified by ImmTrac2 and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac2 website at dshs.texas.gov/immunize/immtrac/.

VACCINES FOR CHILDREN

The Department of State Health Services (DSHS) uses the Center for Disease Control and Prevention (CDC) federal contracts to purchase vaccines at federal contract prices for provision to providers enrolled in Medicaid. Vaccines not available on a federal contract will be purchased using a state contract price or using state purchasing procedures for vaccines not on a state contract. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the ACIP.

DSHS will purchase, store and distribute vaccines purchased using the Texas Vaccines for Children (TVFC) program. DSHS will monitor vaccine reports and track vaccine distribution to Medicaid providers to assure an adequate inventory of vaccines for Medicaid providers. Vaccines are ordered through regional and local health departments. A TVFC provider may not charge for the vaccine itself, but is permitted to charge an administration fee.

If you are not enrolled in the TVFC program, contact the DSHS TVFC division at 1-800-252-9152. To enroll, a provider must:

- Fill out the Provider Enrollment and Provider Profile forms.
- Agree to screen for eligibility.
- Agree to maintain screening records.

More information is available at dshs.texas.gov/immunize/tvfc/. Providers will not be reimbursed for a vaccine that is available through TVFC.

DENTAL CHECKUPS

Primary and preventive dental services for STAR members are covered from birth through twenty (20) years of age, except Oral Evaluation and Fluoride Varnish benefits (OEFV) provided as part of a Texas Health Steps (THSteps) medical checkup for Members age six (6) months through thirty-five (35) months. Children should have their first dental checkup at six (6) months of age and every six (6) months thereafter. Services may include but are not limited to:

- Medically necessary dental treatment for exams.
- Cleanings.
- X-rays.
- Fluoride treatment.
- Orthodontia.
- Restorative treatment.

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Children under the age of six (6) months can receive dental services on an emergency basis.

First Dental Home

First Dental Home (FDH) is a package of services aimed at improving the oral health of children six (6) months through thirty-five (35) months of age. FDH is provided by enrolled THSteps pediatric and general dentists. In addition to a standard set of services, FDH provides simple, consistent messages to parents or caregivers of very young children about proper oral health. To find a certified FDH provider for Texas Star members, contact:

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

Oral Evaluation and Fluoride Varnish

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers limited oral health services provided by THSteps enrolled physicians, physician assistants and advance practice registered nurses. The service is provided in conjunction with the THSteps medical checkup and includes immediate oral evaluation, fluoride varnish application, dental anticipatory guidance and referral to a dental home.

Providers must attend the FDH training or OEFV training offered by the Department of State Health Services (DSHS) Oral Health program to be certified to bill for these services. For more information on both programs, go to dshs.texas.gov/dental/.

An OEFV visit is billed utilizing CPT code 99429 with U5 modifier. The service must be billed with one of the following medical checkup codes: 99381, 99382, 99391 or 99392. The provider must document all components of the OEFV on the appropriate documentation form and maintain record of the referral to a dental home. Federally Qualified Health Centers and Rural Health Centers do not receive additional reimbursement for these services.

TEXAS HEALTH STEPS BILLING

A listing of the Texas Health Steps (THSteps) codes for each of the different exam types, immunizations, TB skin tests and newborn hereditary/metabolic tests are included in the THSteps Quick Reference Guide and the Texas Medicaid Provider Procedures Manual (TMPPM) found on the Texas Medicaid & Health Partnership (TMHP) website at

tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsORG/THSteps_ORG.pdf.

COMPREHENSIVE CARE PROGRAM (CCP)

The Comprehensive Care Program (CCP) is an expansion of the Texas Health Steps (THSteps) program. CCP services are designed to treat and improve specific physical and mental health problems of Medicaid-eligible children identified during the THSteps checkup. These services may include:

- Psychiatric hospitals.
- Private duty nurses.
- Occupational therapy.
- Durable medical equipment.
- Medical supplies.
- Licensed professional counselors.
- Licensed social workers with at least a masters degree.
- Advanced clinical practitioners.
- Dieticians.

Refer to the Texas Medicaid Provider Procedures Manual for more information regarding THSteps and CCP services.

DOCUMENTATION OF COMPLETED TEXAS HEALTH STEPS COMPONENTS AND ELEMENTS

Each of the six (6) components and their individual elements according to the recommendations established by the Texas Health Steps (THSteps) periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual (TMPPM) 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

SECTION V. TEXAS HEALTH STEPS

individual elements. These are outlined on the THSteps 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 THSteps Tuberculosis Questionnaire is required annually beginning at twelve (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 (zero (0) to two (2) years), and blood pressure (three (3) to twenty (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 (ImmTrac2).
- 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 THSteps newborn screens to the Department of State Health Services (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 THSteps medical checkup.
 - Anemia screening at twelve (12) months.
 - Dyslipidemia Screening at nine (9) to twelve (12) years of age and again eighteen (18) to twenty (20) years of age.
 - HIV screening at sixteen (16) to eighteen (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 six (6) months until the parent or caregiver reports a dental home is established.
 - Clients must be referred to establish a dental home beginning at six (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.

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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 txhealthsteps.com.

CHILDREN OF MIGRANT FARMWORKERS

Children of Migrant Farmworkers due for a Texas Health Steps (THSteps) 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 THSteps 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.

Providers should notify Texas Children's Health Plan when they identify a member who is a traveling farmworker or the child of a traveling farmworker by calling 832-828-1430. This will allow our Care Coordination Team to complete an assessment to better coordinate and accelerate services for that member.

SECTION VI. BEHAVIORAL HEALTH PROGRAM

The primary goal of the Behavioral Health Program is to provide medically necessary care in the most clinically appropriate and cost effective therapeutic settings. By ensuring that all Texas Children's Health Plan members receive timely access to clinically appropriate behavioral health care services, Texas Children's Health Plan believes that quality clinical services can achieve improved outcomes for our members.

Improved health outcomes can be achieved by providing members with access to a full continuum of mental health and substance use services through our network of contracted behavioral health providers.

BEHAVIORAL HEALTH SERVICES EXPLAINED

Behavioral health services are covered services for the treatment of mental or emotional disorders and for the treatment of substance use disorders. Behavioral Health is defined as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA).

Texas Children's Health Plan will coordinate the behavioral health services, which include but are not limited to the services listed in the Medicaid (STAR) and CHIP Covered Services section. These services include acute, diversionary and outpatient services.

Texas Children's Health Plan will work with participating behavioral health care practitioners, primary care providers, medical/surgical specialists, organizational providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:

- Educational programs to promote prevention of substance use.
- Parenting skills training.
- Developmental screening for children.
- Attention Deficit Hyperactivity Disorder (ADHD) screening.
- Postpartum depression screening.
- Depression screening in adults.

Please note, inpatient hospital services require authorization. This includes services provided in freestanding psychiatric facilities for children and adults enrolled in the Medicaid (STAR) and CHIP programs.

PRIMARY CARE PROVIDER'S ROLE IN BEHAVIORAL HEALTH

Primary Care Providers (PCPs) may provide behavioral health services within the scope of their practice. PCPs are responsible for coordinating the member's physical and behavioral health care, including making referrals to behavioral health providers when necessary. However, the member does not need a referral to access mental health or substance use disorder treatment with a participating Texas Children's Health Plan provider. The PCP serves as the "medical home" for the member.

PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. PCPs can also reference Texas Children's Health Plan's Clinical Practice Guidelines at texaschildrenshealthplan.org/for-providers/provider-resources/practice-guidelines to assist in making appropriate referrals.

BEHAVIORAL HEALTH PROVIDER REQUIREMENTS

Behavioral health providers agree to:

- Refer members with known or suspected physical health problems or disorders to the Primary Care Provider (PCP) for examination and treatment, with the consent of the member or the member's legal guardian.
- Only provide physical health services if such services are within the scope of the network practitioner's clinical licensure.
- Send initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the consent of the member or the member's legal guardian.
- Contact members who have missed appointments within twenty-four (24) hours to reschedule appointments.

SECTION VI. BEHAVIORAL HEALTH PROGRAM

- Network Facilities and Community Mental Health Centers must ensure members who are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- Provide an attestation to MCO that organization has the ability to provide, either directly or through sub-contract, the members with the full array of Mental Health Rehabilitative (MHR) and Targeted Care Management (TCM) services as outlined in the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) (as part of Credentialing process).
- Annually complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA) and/or Child and Adolescent Needs and Strengths (CANS) assessment tools if providing MHR and TCM.
- Use RUMG as the medical necessity criteria for Mental Health Rehabilitation and TCM services.

MEMBER ACCESS TO BEHAVIORAL HEALTH SERVICES

Texas Children's Health Plan members may access behavioral health services through several mechanisms. These include:

- A referral from their Primary Care Provider (PCP).
- Member self-referral to any Texas Children's Health Plan network behavioral health provider.
- Contacting Texas Children's Health Plan Directly at 1-866-959-2555 (STAR) or 1-866-959-6555 (CHIP).

EMERGENCY BEHAVIORAL HEALTH SERVICES

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. In an emergency, without immediate intervention and/or medical attention, the member would present an immediate danger to himself/herself or others, or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

There is no required pre-certification or notification of emergency services, including emergency room and ambulance services. For questions regarding emergency behavioral health services, please contact 1-800-731-8529 for STAR or 1-800-731-8528 for CHIP.

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

Texas Children's Health Plan requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment with a network behavioral health provider. The outpatient treatment must occur within seven (7) days from the date of and again within thirty (30) days from the date of discharge. The appointment must be with a network psychiatrist, psychologist or therapist. Missed appointments must be rescheduled within twenty-four (24) hours.

Due to appointment availability, it may be necessary to schedule the initial seven (7) day follow-up appointment with a therapist and continue treatment with the therapist until the psychiatric thirty (30) day follow-up appointment is met.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Treatment of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Texas Children's Health Plan will reimburse providers for the treatment of Attention Deficit Hyperactivity Disorder in children who are eligible members and for any follow-up visits when medications have been prescribed to treat ADHD.

Primary Care Providers (PCPs) should complete a visit with all members prescribed ADHD medications within thirty (30) days of starting the medication to evaluate efficacy and assess adverse side effects before prescribing further medication. Members who remain

SECTION VI. BEHAVIORAL HEALTH PROGRAM

on the medication should have at least two additional visits within nine (9) months after the initial thirty (30) day visit.

NON-COVERED BEHAVIORAL HEALTH SERVICES

Members can access local community resources for behavioral health services that are not covered by Texas Children's Health Plan. Services may be sought through the local office of the Texas Department of State Health Services (DSHS) or located through the Texas 211 website at 211texas.org.

Members may also receive services through the Local Mental Health Authority (LMHA). The LMHA accepts patients with chronic mental health disorders (i.e. schizophrenia, bipolar disorder, severe major depression). In the event that a Texas Children's Health Plan member will need to access services through the Local Mental Health Authority, Texas Children's Health Plan will assist the member through the LMHA system of care.

COORDINATION OF CARE

Behavioral health service providers are expected to communicate at least quarterly, and more frequently if necessary, regarding the care provided to each member with other behavioral health service providers and Primary Care Providers (PCPs). Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. Copies of prior authorization forms, referral forms and other relevant communication between providers should be maintained in both providers' files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care.

Please note, medical records and referral information must be documented using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Coordination between Behavioral Health and Physical Health Services

Texas Children's Health Plan is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation or developmental disabilities. Texas

Children's Health Plan will designate behavioral health liaison personnel to facilitate coordination of care and case management efforts.

Coordination with the Local Mental Health Authority

Texas Children's Health Plan will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to the state psychiatric facility. Texas Children's Health Plan will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI) or Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted case management or rehabilitation services through the LMHA.

CONSENT FOR DISCLOSURE OF INFORMATION

Providers are required to obtain a consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider and the member's physical health provider. If the member refuses to release the information, they should indicate their refusal on the release form. In addition, the provider will document the reasons for declination in the medical record. Texas Children's Health Plan monitors compliance of the behavioral health providers to ensure a consent and an authorization to disclose information form has been signed by the member.

COURT-ORDERED COMMITMENTS AND CLAIMS

A "Court-Ordered Commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Texas Children's Health Plan is required to provide inpatient psychiatric services as a condition of probation to members under the age of twenty-one (21), up to the annual limit, 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, related to Court-Ordered Commitments to psychiatric facilities.

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Texas Children's Health Plan will not deny, reduce or controvert the medical necessity of the court-ordered services listed below for persons who are age 20 years of age and younger or 65 years of age and older. In these situations, the court order is considered the determination of medical necessity. Any modification or termination of services will be presented to the court with jurisdiction over the matter for determination. . A member who has been ordered to receive treatment under the provisions of the Texas Health and Safety Code cannot appeal the commitment through Texas Children's Health Plan's complaint or appeals process.

The following court-ordered services are required to be provided to Medicaid eligible persons who are not considered incarcerated:

- Emergency detention ordered by a judge or magistrate under Title 7 Texas Health and Safety Code 573.011 – 573.026
- Mental health services ordered under Title 7 Texas Health and Safety Code 574.01 – 574.110.
- Mental health services may include:
 - o A mental health examination
 - o Inpatient or outpatient treatment
 - o Detention under protective custody and temporary mental health services.
- Treatment of persons who are found not guilty based on lack of responsibility under Title 3 Texas Family Code 55
- Treatment that is a condition of probation.
- Treatment of persons with chemical dependencies ordered under Title 6 Texas Health and Safety Code 462.042

For authorization of court-ordered services, the provider must submit documentation that includes:

- The court-order
- Information about the statute under which the court is ordering the services.
- Verification of the person's incarceration status.

For court-ordered inpatient admissions, providers must submit documentation that includes:

- A copy of the doctor's certificate.
- All court ordered commitment papers signed by a judge.

For persons with fee-for-service benefits, this supporting documentation must be submitted with the Psychiatric Inpatient Extended Stay Request Form.

Requested Services beyond those that are court-ordered are subject to medical necessity review.

Texas Children's Health Plan will comply with utilization review of chemical dependency treatment. Chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.

MEDICAL RECORD REVIEWS

Texas Children's Health Plan reviews member records and uses data generated to monitor and measure provider performance in relation to a variety of quality initiatives established each year. The following elements may be evaluated:

- Use of screening tools for assessment of substance use and Attention Deficit Hyperactivity Disorder (ADHD).
- Continuity and coordination with Primary Care Providers (PCPs) and other providers.
- Explanation of member rights and responsibilities.
- Inclusion of all applicable required medical record elements.
- Allergies and adverse reactions; medications; physical exam.
- Documentation related to measures included in HEDIS health plan standards

Texas Children's Health Plan may conduct chart reviews on site at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to the health plan. HIPAA regulations permit providers to disclose information without patient authorization for the following reasons: "oversight of the health care system, including quality assurance activities." Texas Children's Health Plan chart reviews fall within this area of allowable disclosure.

SECTION VI. BEHAVIORAL HEALTH PROGRAM

MENTAL HEALTH TARGETED CASE MANAGEMENT (MHTCM) AND MENTAL HEALTH REHABILITATIVE (MHR) SERVICES

Severe and Persistent Mental Illness (SMPI)

A Severe and Persistent Mental Illness (SMPI) is a mental illness with complex symptoms that require ongoing treatment and management, most often consisting of varying types and dosages of medication and therapy.

Severe Emotional Disturbance (SED)

A Serious Emotional Disturbance (SED) means a diagnosable mental, behavioral or emotional disorder that severely disrupts a child's or adolescent's ability to function socially, academically and emotionally, at home, in school or in the community, and has been apparent for more than a six (6) month period.

Targeted case management services are case management services to clients within targeted groups. The target population that may receive Mental Health Targeted Case Management (MHTCM) as part of the Texas Medicaid Program are clients, regardless of age, with a single diagnosis of chronic mental illness or a combination of chronic mental illnesses as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to be in need of MHTCM services. Clients of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for Mental Health Targeted Case Management (MHTCM) services.

Mental Health Rehabilitative Services

Mental Health Rehabilitative (MHR) services are defined as age-appropriate services determined by Texas Health and Human Services Commission (HHSC) and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders for children, and to restore the member to his or her best possible functioning level in the community.

Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan. MHR services require prior authorization through Texas Children's Health Plan.

Provider Requirements

A qualified provider of MHTCM and MHR services must complete the following:

- Training and certification to administer Adult Needs and Strengths (ANSA).
- Training and certification to administer Child and Adolescent Needs and Strengths (CANS).
- Providers must follow current Resiliency and Recovery Utilization Management Guidelines (RRUMG).
- Attestation from provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the members with the full array of MHR and MHTCM services as outlined in the RRUMG.
- Texas HHSC established qualification and supervisory protocol.

FOCUS STUDIES AND UTILIZATION REPORTING REQUIREMENT

Texas Children's Health Plan has integrated behavioral health into its Quality Improvement Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to health plan members. A special focus of these activities is the improvement of physical health outcomes associated with behavioral health integration into the member's overall care. Texas Children's Health Plan will routinely monitor claims, encounters, referrals and other data for patterns of potential over and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

SECTION VII. PHARMACY SERVICES

PHARMACY DEPARTMENT RESPONSIBILITIES

Texas Children's Health Plan's Pharmacy Department has oversight on how the pharmacy benefit is administered. The Pharmacy Department's responsibilities include: promoting effective use of medications, ensuring member access to needed medications, assuring medications are a covered benefit and medically necessary; employing tools to review medication utilization and appropriateness; supporting the care management model; and staying compliant to the Health and Human Services Vendor Drug Program requirements for Medicaid and CHIP. Additionally, the Pharmacy Department works with providers to review cost effective use of medications, and to provide feedback about current prescribing patterns to improve the quality of patient care.

Other duties completed by the pharmacy team include, but are not limited to:

- reviewing medication appeals and exceptions resulting from denied prior authorization requests;
- communicating formulary changes proactively that so members and providers are not disrupted;
- creating, managing, and tracking clinical population health initiatives to improve quality of care for members
- actively monitoring utilization to guard against over-utilization of services and fraud or abuse and to address gaps in care or under-utilization of needed medications;
- participating in care management to promote optimal use of medication and reduce potentially preventable hospitalization and emergency department visits;
- assisting providers with the coordination of prescription services.

FORMULARY MANAGEMENT

Texas Children's Health Plan will manage the provision of medications to members utilizing the Texas Vendor Drug Program (VDP) formulary for all Medicaid and CHIP programs.

Prior Authorization

Texas Children's Health Plan's Pharmacy Benefits Manager (PBM), Navitus Health Solutions processes pharmacy prior authorizations. The formulary, prior authorization criteria and the length of the prior

authorization approval are determined by Texas Health and Human Services Commission (HHSC) Information regarding prior authorization criteria can be found at the Vendor Drug Website, (<https://www.txvendordrug.com/formulary/prior-authorization>), Navitus website (txstarchip.navitus.com), Epocrates Point of care application or website, and SureScripts for ePrescribing. Texas Children's Health Plan's authorization list is available on our website at texaschildrenshealthplan.org/for-providers.

Prescribers can access prior authorization forms online at Navitus's website, Texas Medicaid STAR/CHIP/STARKIDS, <https://txstarchip.navitus.com>, or have them faxed by Navitus's Customer Care to the prescriber's office. Prescribers can also log into the Navitus Provider Portal using their national provider identifier (NPI). Completed forms can be faxed 24/7 to Navitus at 1-855-668-8553. Providers may also contact the Navitus Customer Care team for questions, or to request conducting prior authorizations over the telephone toll-free at 1-877-908-6023.

Please note that Navitus does not review appeal requests for denied prior authorizations requests. Appeal requests should be directed to Texas Children's Health Plan. Appeal requests can be faxed to 832-825-8796. Questions should be directed to Texas Children's Health Plan at 1-866-959-2555.

Formulary and Preferred Drug List

Information regarding the formulary can be found at the Vendor Drug Website (<https://www.txvendordrug.com/formulary>), Navitus website (txstarchip.navitus.com). Within the formulary is a preferred drug list (PDL) for STAR members. The PDL does not apply to CHIP members. The PDL and prior authorization criteria for non-preferred medications are available at txvendordrug.com/pdl.

A list of covered drugs and preferred drugs may also be accessed through our Pharmacy Benefits Manager, Navitus. To contact Navitus:

- Log onto the Navitus Provider Portal at navitus.com
- Call the Navitus Texas Provider Hotline at 1-877-908-6023

SECTION VII. PHARMACY SERVICES

Emergency Prescription Supply

A seventy-two (72) hour emergency supply of a prescribed drug must be provided if a medication requires a prior authorization, but the prescribing provider cannot be contacted, and the dispensing pharmacist believes delay in therapy may cause patient harm. This applies to all drugs requiring a prior authorization, including non-preferred drugs or those subject to clinical edits.

The seventy-two (72) hour emergency supply should be dispensed upon the dispensing pharmacist's professional discretion. 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 seventy-two (72) hour emergency supply.

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

- "8" in 'Prior Authorization Type Code' (field 461-EU).
- "801" in 'Prior Authorization Number Submitted' (field 462-EV).
- "3" in 'Days Supply' (field 405-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 (3) day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three (3) 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 Navitus's Texas Provider Hotline toll free at 1-877-908-6023 for more information about the seventy-two (72) hour emergency prescription supply policy.

Pharmacy Compounds

Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Compounds must contain medication(s) that are covered by the VDP formulary. The pharmacy should bill a compound properly using a compound indicator. Medicaid does not reimburse for non-formulary medications or other excipients.

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 select drugs.

PHARMACY LOCK-IN PROGRAM

Texas Children's Health Plan's Pharmacy Department routinely monitors drug or medical claims for over-utilization, fraud, waste or abuse. Texas Children's Health Plan will follow current Office of Inspector General (OIG) criteria with respect to locking a member to a single pharmacy who met criteria. Upon review, a member is locked via our Pharmacy Benefits Manager, Navitus, platform and claims will adjudicate only to the identified assigned pharmacy. Members are notified directly by the OIG if criteria met lock-in requirements. Additionally, the Texas Children's Health Plan Pharmacy team will work with appropriate parties to refer the member for other services such as but not limited to behavioral health consultation or drug treatment, etc. as appropriate.

SPECIALITY DRUG PROGRAM

Texas Children's Health Plan provides coverage for products defined as specialty drugs per the Texas Vendor Drug Program (VDP) under the pharmacy benefit. The specialty drug list (SDL) can be found on the VDP website, txvendordrug.com/formulary/formulary/specialty-drugs.

SECTION VII. PHARMACY SERVICES

PHARMACY BENEFITS

Texas Children's Health Plan works through its PBM Navitus to provide pharmacy benefits. Medicaid (STAR) and CHIP members have access to a large network of pharmacies for prescription needs. The network includes retail chains, independent pharmacies, specialty pharmacies and mail order pharmacies. Navitus only covers drugs and durable medical equipment (DME) allowed by the Texas Vendor Drug Program (VDP) formulary. Medicaid (STAR) and CHIP members may receive up to a ninety (90) day supply of a drug for treating a chronic condition. For a full listing of pharmacies in Texas Children's Health Plan's network, go to texaschildrenshealthplan.org/for-providers.

Medicaid (STAR) members also have access to limited home health supplies that may be billed through the member's pharmacy benefit. A list of these supplies can be found at <https://www.txvendordrug.com/formulary/formulary/home-health-supplies>.

DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY

Texas Children's Health Plan, working through Navitus, reimburses for some 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), Navitus 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 enroll in Texas Children's Health Plan's network by contacting Navitus at 1-608-298-5775 or via email at providerrelations@navitus.com.

A limited set of basic home health supplies are available under the Vendor Drug Program (VDP) Formulary. Pharmacies will be reimbursed for filling prescriptions for supplies for clients in the Medicaid program. The list of supplies can be found on the Limited Home Health Supplies (LHHS) page on the VDP website at txvendordrug.com/formulary/formulary/home-health-supplies. Pharmacies do not have to be enrolled as DME providers to submit claims for these supplies.

Please refer to the Claims and Billing Section of this Provider Manual for additional information related to claims submission.

Call the Navitus Provider Hotline at 1-877-908-6023 for more information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

NAVITUS PHARMACY PROVIDER RELATIONS

Navitus Provider Relations can assist providers with:

- Network participation.
- Network access reports.
- Contract questions.
- Pharmacy credential review.
- Reimbursement and remittances.
- Maximum Allowable Cost list (MAC).
- Network system set up.
- Pharmacy performance analysis and reporting.
- Pharmacy communication.

Providers can contact Navitus Provider Relations at:

Pharmacy Provider Relations/Contracts:

1-866-333-2757

Fax: 1-866-808-4649

Email: providerrelations@navitus.com

For credentialing, providers should contact Navitus at:

Credentialing: 608-298-5776

Fax: 608-298-5876

Email: credentials@navitus.com

SECTION VIII. DENTAL SERVICES

EMERGENCY DENTAL SERVICES

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.

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.

NON-EMERGENCY DENTAL SERVICES

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 aged six (6) through thirty-five (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 and document member's main dental home choice in the members' file.

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.

SECTION IX. CLAIMS AND BILLING

CLAIMS INFORMATION

A claim is a request for reimbursement, either electronically or by paper, for any health care service provided. A claim must be filed on the approved claim form such as CMS 1500 or UB-04/CMS 1450. Any UB-04/CMS 1450 and CMS 1500 paper claim forms received that do not meet the CMS printing requirements will be rejected and sent back to the provider upon receipt.

A clean claim is a claim submitted on an approved standardized claim form (CMS 1500 or UB-04/CMS 1450) that contains all data fields required by Texas Children's Health Plan, as specified in this section for adjudication of the claim as a clean claim. The required data fields must be complete and accurate. A clean claim must include all published clean claim requirements including Tax Identification Number (TIN), National Provider Identifier (NPI) and taxonomy.

CLAIMS FILING DEADLINE

A provider must file a claim with Texas Children's Health Plan within ninety-five (95) days from the date of service. If a claim is not received by Texas Children's Health Plan within ninety-five (95) days, the claim will be denied unless supporting documentation is received explaining why an exception should be considered.

If the provider files a claim with the wrong plan within the ninety-five (95) day submission requirement, Texas Children's Health Plan will process the initial claim if the claim is filed within ninety-five (95) days of the denial remit from the incorrect plan/payer. The provider must file the claim with the correct Managed Care Organization within ninety-five (95) days of the disposition date from the other (wrong) carrier. The provider must submit the original claim and Explanation of Payment (EOP) from the other carrier.

Texas Children's Health Plan must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the date of service within ninety-five (95) days from the date the eligibility was added to the TMHP eligibility file. Eligibility for Texas Children's Health Plan members can be verified on Texas Children's Health Plan's Provider Portal at texaschildrenshealthplan.org/for-providers.

If an individual becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the ninety-five (95) day filing deadline begins on the date that the eligibility start date was added to Texas Medicaid & Healthcare Partnership (TMHP) files.

After filing a claim with Texas Children's Health Plan, providers should review their EOP(s). If within forty-five (45) days, the claim does not appear on the EOP as a paid, denied or incomplete claim, the provider should resubmit the claim to Texas Children's Health Plan within ninety-five (95) days of the date of service.

Nonparticipating providers located in Texas must submit clean claims to Texas Children's Health Plan within ninety-five (95) days of service. Nonparticipating providers located outside of Texas must submit clean claims to us within 365 days of the date of service. To submit claims for services provided to Medicaid (STAR) and CHIP members, providers must have an active Texas Provider Identifier (TPI) on file with TMHP, the state's contracted administrator.

PROCESSING AND PAYMENT REQUIREMENTS

Texas Children's Health Plan must administer an effective, accurate and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the contract, including Chapter 2 of the Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual. Texas Children's Health Plan must be able to accept and process Medicaid claims in compliance with the Texas Medicaid Provider Procedures Manual (TMPPM).

Upon receipt of a clean claim, Texas Children's Health Plan will adjudicate the claim for payment or denial within the thirty (30) day claim processing timeframe. If denied in whole or in part, Texas Children's Health Plan will notify the provider of why the claim will not be paid via the Electronic Remittance Advice (ERA) or Explanation of Payment (EOP).

The date of claim payment is the date of issue of a check for payment, or the date of Electronic Funds Transmission (EFT) if payment is made electronically.

SECTION IX. CLAIMS AND BILLING

Texas Children's Health Plan will not pay a claim submitted by a provider if:

- Provider is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, abuse or waste.
- Provider is on payment hold under the authority of Texas HHSC or its authorized agent(s).
- For neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from Texas HHSC.*
- For maternal services provided on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from Texas HHSC.*
- Provider is not enrolled in Texas Medicaid, other than for exceptions outlined in the Texas Medicaid Provider Procedures Manual.

*In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.

Payment of clean claims to providers who render medically necessary covered services to members, for whom a capitation has been paid to Texas Children's Health Plan, shall be done in an accurate and timely manner, as per our contract.

CLAIMS SUBMISSION INFORMATION

Paper Claims Submission

All Texas Children's Health Plan Medicaid (STAR), CHIP, CHIP Perinate and CHIP Perinate Newborn claims should be submitted to:

Texas Children's Health Plan
P.O. Box 300286
Houston, Texas 77230-0286

Hospital inpatient claims for CHIP Perinate Newborns with a family income at or below 198% of the Federal Poverty Level (FPL) should be sent to:

TMHP
P.O. Box 200555
Austin, Texas 78720-0555

Special instructions for CHIP Perinate claims:

- All inpatient hospital claims submitted for CHIP Perinate members who are 0-198% FPL should be submitted to TMHP as these claims are not processed by Texas Children's Health Plan.
- All inpatient hospital claims submitted for CHIP Perinate members above the Medicaid threshold should be submitted to Texas Children's Health Plan.

Electronic Claim Submission

Texas Children's Health Plan encourages all providers to file claims and/or encounters electronically. Providers can use vendor software or a third party billing agent (e.g., billing companies and clearinghouses) to participate in Texas Children's Health Plan's electronic claims/encounters filing program through Change Healthcare. This clearinghouse provides a secure platform where providers can submit single claim submissions at no cost. Change Healthcare has the capability to receive electronic professional, institutional and encounter transactions and generate the electronic Explanation of Payment (EOP). Providers may contact Change Healthcare at 1-866-506-2830.

Submission of a claim to the clearinghouse does not guarantee that the claim was transmitted or received by Texas Children's Health Plan. Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports.

Product	Clearinghouse	Payer ID
CHIP (both professional and institutional claims)	Change Healthcare	76048
STAR (professional claims)	Change Healthcare	TH077
STAR (both professional and institutional claims)	Change Healthcare	75228

SECTION IX. CLAIMS AND BILLING

If applicable, Texas Children's Health Plan requires that providers submit the appropriate Billing Provider NPI and Taxonomy and the appropriate Rendering Provider NPI and Taxonomy fields on all electronic claims.

Pharmacy Electronic Claim Submission

All electronic pharmacy provider claims that are clean and payable must be paid within eighteen (18) days from the date of claim receipt. Non-electronic claims that are clean and payable must be paid within twenty-one (21) days from the date of claim receipt. Pharmacy providers may submit claims using the electronic transmission standards set forth in CFR Parts 160, 162 or 164; and by using a universal claim form that is acceptable to the Pharmacy Benefits Manager, Navitus Health Solutions.

For a list of covered drugs and preferred drugs, prior authorization process, claim submission requirements, including allowable billing methods and special billing, or for general pharmacy questions, providers may contact Navitus Health Solutions directly through the Navitus Provider Portal at navitus.com or call the Navitus Pharmacy Help Desk at 1-877-908-6023.

Electronic Claim Acceptance

Providers should confirm receipt of submitted claims through Texas Children's Health Plan's Provider Portal on our website at texaschildrenshealthplan.org/for-providers. Claim status may be verified by individual claim number or in batches with a claim status report. Providers must also track claim submissions against their claims payments to detect and correct all claim errors. Claims that are rejected or denied must be corrected and resubmitted within timely filing guidelines for payment consideration.

After filing a claim to Texas Children's Health Plan, providers should review their EOPs. If within forty-five (45) days, the claim does not appear on the EOP as a paid, denied or incomplete claim, the provider should resubmit the claim to Texas Children's Health Plan within ninety-five (95) days of the date of service to ensure timely filing.

ELECTRONIC FUNDS TRANSFERS AND ELECTRONIC REMITTANCE ADVICES

Texas Children's Health Plan provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to participating providers to help reduce costs, improve speed for secondary billings and improve cash flow by enabling online access of remittance information

and straight forward reconciliation payments. As a provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses - ERAs can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improve cash flow - Electronic payments mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts - Keep total control over the destination of claim payments for multiple practices and accounts.
- Match payments to advices quickly - Associate electronic payments with ERAs quickly and easily.

For more information on EFT and ERA services, please contact Change Healthcare, our electronic billing partner, at 1-866-506-2830.

PAYMENT/ACCRUAL OF INTEREST BY TEXAS CHILDREN'S HEALTH PLAN

Texas Children's Health Plan will include interest payment on claims for the full period in which a clean claim or a portion of the clean claim remains unadjudicated. If deemed eligible for interest, the interest payment will be calculated at an eighteen (18) percent annual rate, calculated daily. The principal amount on which interest will be calculated is the amount due but unpaid at the contracted rate for the service.

CLAIM STATUS ASSISTANCE

Texas Children's Health Plan offers several methods to access claim status.

Provider Portal

Texas Children's Health Plan's Provider Portal offers resources to assist your office. Go to our website at texaschildrenshealthplan.org/for-providers to log into the Provider Portal.

New providers will be required to enter information such as your Tax Identification Number (TIN), provider National Provider Identifier (NPI), contact name and email address. Once you complete and submit the registration form, you will receive an email confirmation to validate your account.

Multiple staff members within one office or group can have an account. Each user within the office must create their own unique user name and password. Sharing accounts between staff is not permitted.

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Please check with your office administrator before registering to determine if your practice has portal access. If your practice already has portal access, the administrator can simply add you to the existing account for the practice.

Automated System

Telephone TouCHPoint is an automated self-service application available to providers twenty-four (24) hours a day, seven (7) days a week. Providers can utilize the automated feature to verify eligibility, benefits, and claim status.

Features include:

- No waiting for a live rep.
- Choose verbal playback or email back.
- No limits on the amount of status requests.
- Allows you to go back to main menu or speak to a live representative (applicable during regular business hours).

How to use Telephone TouCHPoint:

1. Call 832-828-1007.
2. Enter the member's identification number and the provider's NPI number.
3. To hear a claim status, you will need your NPI number as well as the tax identification number for which the claim was billed.

PROVIDER REIMBURSEMENT

Texas Children's Health Plan will reimburse providers according to their contractual agreement. Texas Children's Health Plan cannot reimburse providers for Medicaid services unless the provider is enrolled with Texas Medicaid & Healthcare Partnership (TMHP) and is included on the state master provider file. The TMHP state master provider file is updated weekly.

Texas Children's Health Plan will reimburse providers who render medically necessary covered services to eligible members, for whom a capitation has been paid to Texas Children's Health Plan. To verify a covered service, please contact Texas Children's Health Plan at 832-828-1004.

Texas Children's Health Plan requires tax identification numbers from all participating providers. The health plan is required to do back-up withholding from all payments to providers who fail to give tax identification numbers or who give incorrect numbers.

CLAIM DOCUMENTATION REQUIREMENTS

Providers must include or adhere to the following documentation guidelines when considering claim submission:

NPI and Taxonomy Codes

Providers must submit the appropriate Billing National Provider Identifier (NPI) and Taxonomy code and the appropriate Rendering NPI and Taxonomy on all electronic and paper claim submissions. The rendering provider is the individual who provided the care to the member. If a rendering provider is available, the rendering provider NPI and Taxonomy must be included on the claim.

It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with Texas Medicaid & Healthcare Partnership (TMHP) is included on all electronic and paper claim submissions. Claims submitted without a taxonomy code will be denied. Taxonomy codes are used to crosswalk the NPI to a TPI.

Texas Children's Health Plan will deny claims with an unattested NPI, even if you provide legacy information. Attestation is the process of registering and reporting your NPI with your state Medicaid agency. Providers serving Texas Medicaid (STAR) patients are required to register and attest their NPI with TMHP. You can attest (register and report) your NPI with TMHP at tmhp.com.

National Drug Code

The National Drug Code (NDC) is an eleven (11) digit number on the package or container from which the medication is administered. All providers must submit an NDC for professional or outpatient claims submitted with physician administered prescription drug procedure. Claims that do not have this information will be denied.

A National Drug Code (NDC) is composed of three sets of numbers:

- The first five numbers are assigned by the Food and Drug Administration (FDA) and identify the labeler, meaning the manufacturer, repackager, or distributor of the drug.
- The middle four numbers are the product code. It identifies the specific strength, dosage form, i.e. capsule, tablet, liquid, etc., and the formulation of a drug for a specific manufacturer.

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- The last two numbers are the package code, which identifies package sizes and types.

N4 must be entered before the NDC on claims. The National Drug Unit of Measure must also be included. The submitted unit of measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas National Drug Code (NDC)-to-Healthcare Common Procedure Coding System (HCPCS) Crosswalk.

The valid units of measurement codes are:

- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit

Note: Unit quantities are required.

National Correct Coding Initiative Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation. The Centers for Medicare and Medicaid Services (CMS), National Council on Compensation Insurance (NCCI) and Medically Unlikely Edits (MUE) guidelines can be found in the NCCI Policy and Medicare Claims Processing manuals, which are available on the CMS website.

CPT and HCPCS Claims Auditing Guidelines

Claims must be filed in accordance with the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) guidelines as defined in the American Medical Association (AMA) and CMS coding manuals. Claims that are not filed in accordance with the CPT and HCPCS guidelines may be denied, including claims for services that were prior authorized or authorized based on documentation of medical necessity.

If a rendered service does not comply with the CPT or the HCPCS guidelines, medical necessity documentation may be submitted with the claim for the service to be considered for reimbursement; however, medical necessity documentation does not guarantee payment for the service.

Supervising Physician Provider NPI

The supervising physician provider NPI is required on claims for services that are ordered or referred by one provider at the direction or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the client.

Ordering or Referring Provider NPI

All claims for services that require a physician order or referral must include the ordering or referring provider's NPI. If the ordering or referring provider is enrolled in Texas Medicaid as a billing or performing provider, the billing or performing provider's NPI must be used on the claim as the ordering or referring provider.

Newborn Members Without Medicaid or CHIP ID Numbers

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. Providers can verify CHIP eligibility by contacting the managed care plan selected by the member. Providers must check eligibility regularly to ensure claims are submitted and received within the required ninety-five (95) day filing deadline.

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COORDINATION OF BENEFITS

Medicaid is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid. Texas Children's Health Plan must pay the unpaid balance for covered services up to the agreed rates for network providers and out-of-network providers with written reimbursement arrangements. Texas Children's Health Plan must pay the unpaid balance for covered services in accordance with Texas Health and Human Services Commission's (HHSC) administrative rules regarding out-of-network payment (1 T.A.C. §353.4) for out-of-network providers with no written reimbursement arrangement.

Providers must submit claims to other health insurers for consideration prior to billing Texas Children's Health Plan. For payment consideration, providers must file the claim with a copy of the Explanation of Payment (EOP) or rejection letter from the other insurance to:

Texas Children's Health Plan
Attention: Claims Administration Department
P.O. Box 300286
Houston, TX 77230-0286

Providers have access to verify Coordination of Benefits through the Provider Portal on the Texas Children's Health Plan website at texaschildrenshealthplan.org/for-providers by simply entering the necessary search criteria when verifying member's eligibility.

In cases where the other payer makes payment, the CMS-1500, CMS-1450 or applicable ANSI-837 electronic format claim must reflect the other payer information and the amount of the payment received.

In cases where the other payer denies payment, or applies their payment to the member's deductible, a copy of the applicable denial letter or EOP must be attached with the claim that is submitted to Texas Children's Health Plan. If this information is not sent with an initial claim filed for a member with other insurance, the claim will deny and the EOP will instruct the provider to bill with the appropriate insurance carrier until this information is received.

If a member has more than one primary insurance carrier (Medicaid would be the third payor), the claim should not be submitted through EDI or the Provider Portal and must be submitted on a paper claim.

CHIP member eligibility is based on the absence of any other health insurance, including Medicaid. A patient is not eligible for CHIP if he or she is covered by group health insurance or Medicaid.

OVERPAYMENTS

An overpayment is any payment that a provider receives in excess of the amount payable for a service rendered.

An overpayment may occur due to, but not limited to, the following reasons:

- Duplicate payment.
- Health plan reimbursement error.
- Payment to incorrect provider.
- Payment for the incorrect member.
- Overlapping payment by Texas Children's Health Plan and a third party resource.
- Provider bills incorrectly or in excess of actual charges.

Reporting Overpayments to Texas Children's Health Plan

A provider has an obligation to notify Texas Children's Health Plan in writing immediately upon identification of an overpayment, but no more than thirty (30) days from the date of discovery. The overpayment can be remediated through refund to Texas Children's Health Plan, or a provider may request a recoupment from future claim payments.

The notice of overpayment must include the following details:

- Claim number.
- Refund amount.
- Provider Name.
- Tax identification number and NPI.
- Member name and ID number.
- Date(s) of service

Refund

If a provider wishes to refund the overpayment by issuing a check to Texas Children's Health Plan, the refund check must be submitted within thirty (30) days of notification of the overpayment, or sixty (60) days from the date of the discovery of the overpayment, whichever is less. If a refund check is not received within that timeframe, Texas Children's Health Plan will proceed with recoupment of the overpayment(s).

To submit a refund check, a provider should mail the

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check and supporting documentation to:

Texas Children's Health Plan
P.O. Box 841976
Dallas, TX 75284-1976

Recoupment

If a provider requests Texas Children's Health Plan recoup the overpayment, the prior erroneous payment(s) will be reversed within thirty (30) to sixty (60) days of receipt of the request. When the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's Explanation of Payment (EOP) after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

To submit a request to recoup an overpayment, a provider should mail the written request and supporting documentation to:

Texas Children's Health Plan
Attention: Claims Administration Refund Department
P.O. Box 300286
Houston, TX 77230-0286

Overpayments Identified by Texas Children's Health Plan

Texas Children's Health Plan may also identify overpayments made to a provider. In these circumstances, we will typically reverse the prior payment of the claim and recoup any monies paid in error, unless the provider contract requires, or the provider has previously requested that Texas Children's Health Plan allow the provider the opportunity to refund the overpayment prior to recoupment.

If a provider receives notification of overpayment, and request for refund, the provider should include a copy of the notification of overpayment letter with the refund check and mail to:

Texas Children's Health Plan
P.O. Box 841976
Dallas, TX 75284-1976

If the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

If a provider has requested, or the provider's contract

requires prior notification and opportunity to submit a refund as result of an overpayment identified by Texas Children's Health Plan, the provider will receive a letter explaining the reason for the overpayment, and requesting a refund be submitted within the appropriate timeframe as documented in the overpayment notice to the provider. If the refund is not received within that timeframe, Texas Children's Health Plan will proceed with reversal of the erroneous payment, recouping the payment prior issued.

CORRECTED CLAIMS

A corrected claim is a correction or change of information to a previously finalized clean claim in which additional information from the provider is required. A corrected claim can be the result of:

- An original claim that was either denied or rejected as being deficient, as it did not contain all required elements to appropriately process the claim.
- An original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one (1) or more elements included in the original claim submission were erroneous.

Corrected Claims Process

All corrected claims received from a provider must meet the following criteria in order to be considered as a corrected claim for review:

- A corrected CMS-1500 (HCFA) or CMS-1450 (UB-04) claim form is required.
- Corrected claims must be received within 120 days of the disposition date to meet the timely filing requirements.
- Provider should complete box 22 (Resubmission Code) to include a seven (7) to notify of a corrected claim on a paper CMS-1500.
- The UB-04 type of bill code (field 4) shall include a seven (7) in the third position to indicate the claim is a corrected claim.

Corrected claims can be submitted via EDI, the Provider Portal or on paper. To submit paper corrected claims, mail to the following address:

Texas Children's Health Plan
Attention: Claims Administration Department
P.O. Box 300286
Houston, TX 77230-0286

If submitting corrected claims electronically, the

SECTION IX. CLAIMS AND BILLING

following guidelines must be completed for an ANSI-837P (Professional) and ANSI-837I (Institutional) claim to be considered a corrected claim:

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an adjustment claim as follows:

“7” – REPLACEMENT (Replacement of Prior Claim)

2. In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic remittance advice.

Example: Claim Frequency Code

CLM*12345678*500***11::7*Y*A*Y*I*P~

REF*F8*(Enter the Claim Original Reference Number)

REF01 must contain ‘F8’

REF02 must contain the original Texas Children’s Health Plan claim number.

3. In the 2300 Loop, the NTE segment (free text ‘Claim Note’), must include the explanation for the Corrected/Replacement Claim.

NTE01 must contain ‘ADD’

NTE02 must contain the free-form note indicating the reason for the corrected replacement claim.

Example: NTE*ADD*CORRECTED PROCEDURE CODE ON LINE 3

APPEALING A CLAIM DENIAL

A provider may appeal any disposition of a claim. All appeals of denied claims must be received by Texas Children’s Health Plan within 120 days from the date of disposition (the date of the Explanation of Payment (EOP) on which the claim appears). Texas Children’s Health Plan will process claim appeals and adjudicate the claim within thirty (30) days from the date of receipt of the claim appeal.

Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Texas Children’s Health Plan, or the date of electronic transmission if payment is made electronically.

Any appeal received after the above stated timely filing period will be denied for failure to file an appeal within the required time limits.

SUBMITTING A CLAIMS APPEAL

Providers may submit appeals in writing or through our Provider Portal at texaschildrenshealthplan.org/for-providers. All claims appeals must include all necessary documentation, including the original claim and Explanation of Payment (EOP). Any adjustments as the result of a claim appeal will be provided by check with an EOP, reflecting the adjustment of the claim. .

When submitting claims, please follow these guidelines:

- All claim appeals must be finalized within twenty-four (24) months from the date of service.
- All appeals of claims and requests for adjustments must be received by Texas Children’s Health Plan within 120 days from the date of the last denial of and/or adjustment to the original claim.
- If a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

A Claim Appeal Form is included in the Appendix section of this Provider Manual and must be sent in with an appeal submitted on paper. To submit an appeal on paper, mail or fax the appeal to the following:

Texas Children’s Health Plan
Attention: Claims Administration Department
P.O. Box 300286
Houston, TX 77230-0286
Fax: 1-844-386-3171 (toll free) or 346-232-4710

Texas Children’s Health Plan will process claim appeals and adjudicate the claim within thirty (30) days from the date of receipt of the claim appeal.

MEDICAL NECESSITY CLAIMS APPEAL

A medical necessity appeal is a written request from a member or provider who is appealing on the member’s behalf to reconsider a medical necessity denial. This can apply to a denial for a service that was requested but has not yet been performed, or a retrospective review of a service that has already been performed but is partially or wholly denied. Texas Children’s Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests. Please refer to the Denials and Appeals section of this Provider Manual for instructions on how to submit medical necessity appeals related to Utilization Management.

SECTION IX. CLAIMS AND BILLING

PROVIDER APPEAL PROCESS TO TEXAS HHSC (RELATED TO CLAIM RECOUPMENT DUE TO MEMBER DISENROLLMENT)

Provider may appeal claim recoupment by submitting the following information to Texas Health and Human Services Commission (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 Texas 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

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CENTERS (RHC)

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are reimbursed their assigned encounter rate for services. FQHCs and RHCs must bill a T1015 procedure code and the applicable modifier for general medical services. Exception claims (e.g. Texas Health Steps and Family Planning) must be billed as described in Texas Medicaid Provider Procedure Manual (TMPPM) with the most appropriate procedure code(s) using the required modifier(s) when appropriate and must follow program specific rules. For more information, providers should refer to the Texas Medicaid Procedure Manual at tmhp.com.

Texas Children's Health Plan will pay the full encounter rates to RHCs for medically necessary covered services using the prospective payment methodology. This will be the full payment amount in effect on the date of service for RHCs; cost settlements (or "wrap payments") will not apply. For FQHCs, Texas Children's Health Plan will negotiate the payment amounts for medically necessary covered services provided to its members. The amounts must be greater than or equal to the average of Texas Children's Health Plan's payment terms for other providers providing the same or similar services.

When a member visits an FQHC, RHC or public health clinic for health care at a time that is outside of regular business hours, Texas Children's Health Plan will reimburse for medically necessary covered services at a rate that is equal to the allowable rate for those services.

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DELIVERY AND POSTPARTUM SERVICES BILLING

Claims for delivery and postpartum services must be billed separately for all products. Effective December 1, 2021 Texas Children's Health Plan will reimburse for postpartum visit code 59430 once per pregnancy for STAR, STAR Kids, and CHIP programs.

CHIP Perinate is only allowed two postpartum visits per pregnancy (59430 once only and then E/M code 99211-99215 for the second visit).

Providers must bill CPT Code 59430 one time and use an E/M code 99211-99215 and a diagnosis restriction of postpartum related ICD-10 Codes Z39.0, Z39.1, and Z39.2 for the additional postpartum visits. (Please see the table below for Reimbursable Codes:

Reimbursable Codes		
Procedure Code		Code Description
59409	59612	Vaginal Delivery Only
59514	59620	C-Section Delivery Only
59430		Postpartum Outpatient Visit

Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) at tmhp.com for additional information on delivery and postpartum services.

SECTION IX. CLAIMS AND BILLING

EMERGENCY SERVICES CLAIMS

Texas Children's Health Plan covers emergency services for current members regardless of the location. Emergency service is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the member'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 the woman or her unborn child.

The provider should direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition exists. If an emergency condition does not exist, the provider should direct the member to come to the office. Texas Children's Health Plan does not require that the member receive authorization approval from the health plan or the Primary Care Provider prior to accessing emergency services. To facilitate continuity of care, Texas Children's Health Plan instructs members to notify their Primary Care Provider as soon as possible after receiving emergency services. Providers are not required to notify Texas Children's Health Plan about emergency services.

BILLING MEMBERS

Providers may not bill members directly for STAR or CHIP covered services. Texas Children's Health Plan reimburses only those services that are medically necessary and a covered benefit in the STAR or CHIP programs.

Texas Children's Health Plan STAR, CHIP Perinate and CHIP Perinate Newborn members do not have copayments. CHIP members may share costs. Cost sharing information is included in the Covered Services section of this Provider Manual.

MEMBER ACKNOWLEDGEMENT STATEMENT

A provider may bill a Texas Children's Health Plan member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

- A specific service or item is provided at the request of the patient.
- The provider has obtained and kept a written member acknowledgement statement signed by the client. The member acknowledgment statement must read as follows: "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 Assistance program or the Children's Health Insurance Program as being reasonable and medically necessary for my care. I understand that Texas Children's Health Plan, through its contract with Texas HHSC, determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

A sample of the Member Acknowledgement Statement is located in the Appendix section of this Provider Manual. A Spanish version of the Member Acknowledgment Statement is available in the Provider Enrollment and Responsibilities section of the Texas Medicaid Provider Procedures Manual (TMPPM) on tmhp.com.

SECTION IX. CLAIMS AND BILLING

PRIVATE PAY STATEMENT

A provider is allowed to bill the following to a member without obtaining a signed Member Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (i.e., cellular therapy for pediatrics).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are twenty (20) years of age and younger.
- All services provided as a private pay patient. If the provider accepts the member as a private pay patient, the provider must advise the member 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. In this situation, Texas HHSC strongly encourages the provider to ensure that the patient signs written notification so there is no question how the patient was accepted. Without written, signed documentation, that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The patient is accepted as a private pay patient pending Texas Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely claims. If the client becomes eligible, the provider must refund any money paid by the client and file claims to Texas Children's Health Plan or Texas Medicaid for all services rendered.

A provider who attempts to bill or recoup money from a Texas Children's Health Plan member in violation of the above situations may be reported to the appropriate fraud and abuse unit resulting in exclusion from the Texas Medicaid Program.

Providers are prohibited from including in the contract with their covered members language that limits the member's ability to contest claim payment issues, or that binds the member to the insurer's interpretation of the contract terms.

A sample of the Private Pay Statement is located in the Appendix section of this Provider Manual. A Spanish version of a Private Pay Statement is available in the Provider Enrollment and Responsibilities section of the Texas Medicaid Provider Procedures Manual (TMPPM) on tmhp.com.

OUT OF NETWORK

Claims Submission

Nonparticipating providers located in Texas must ensure that clean claims are received by Texas Children's Health Plan within ninety-five (95) days of the date of service. Nonparticipating providers located outside of Texas must ensure that clean claims are received within 365 days of the date of service. To submit claims for services provided to Medicaid (STAR) and CHIP members, providers must have an active Texas Provider Identifier on file with the Texas Medicaid & Healthcare Partnership (TMHP), the state's contracted administrator.

Authorization

Nonparticipating providers must obtain authorization for all non-emergent services except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated delivery by cesarean section. We require authorization of maternity inpatient stays for any portion in excess of these timeframes.

Reimbursement

Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in the absence of a negotiated rate, at the usual and customary rate.

SECTION X. CARE MANAGEMENT

PRIOR AUTHORIZATION AND CARE MANAGEMENT

Texas Children's Health Plan's Care Management department works with its network providers to facilitate quality care through its refined Care Management Program. This program encompasses utilization management, case management/complex case management and disease management components, as well as other features such as twenty-four (24) hour nurse triage, referrals, second opinions prior authorization/pre-certification, concurrent review, retrospective review, and discharge planning.

UTILIZATION MANAGEMENT

Member Self-Referrals

There are some services to which a member has access without a referral from the Primary Care Provider (PCP). Texas Children's Health Plan's STAR members do not need a referral from their PCP for the following services.

- Family planning.
- THSteps medical and dental checkups.
- Case management for children and pregnant women.
- Vision.
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope).
- True emergency services.
- Well-woman annual examinations.
- OB/GYN care.

Texas Children's Health Plan CHIP members may self-refer for:

- Well-child annual exams.
- Dental.
- Vision.
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope).
- True emergency services.
- Well-woman annual examinations.
- OB care for those who do not qualify for Medicaid.

Observation Stays

Observation stays are for hospital short stays of less than 48 hours.

Service Authorization Requests

Services requiring prior authorization must be reviewed by Texas Children's Health Plan for medical necessity prior to the provision of services to the member. Please visit texaschildrenshealthplan.org/for-providers to use the prior authorization look up tool by code or to submit a prior authorization request through our Provider Portal.

Included in the prior authorization process are:

- Verification of eligibility, determination of medical necessity and benefits.
- Referral of a member to case or disease management programs when appropriate.

Prior Authorization Determinations

Texas Children's Health Plan's Utilization Management Department processes service requests in accordance with the clinical immediacy of the requested services. If priority is not specified on the referral request, the request will default to routine status.

Authorization Type	Turn Around Timeline
Routine	3 business days
Urgent	1 business day
Inpatient	1 business day

Please note, any prior authorization form returned with the language "PA Not Required" does not mean that service is approved. Providers should verify if the service is a covered benefit and requires authorization using the prior authorization tool located on Texas Children's Health Plan's Provider Portal at texaschildrenshealthplan.org/for-providers.

Texas Children's Health Plan may extend the time frame for a standard authorization decision by up to 14 calendar days if the member or provider requests an extension.

Texas Children's Health Plan may also extend the time frame for a standard authorization decision by up to 14 calendar days if additional information is needed and the extension is in the member's best interest.

SECTION X. CARE MANAGEMENT

Prior Authorization is not a Guarantee of Payment

All services are subject to the plan provisions, limitations, exclusions and member eligibility at the time the services are rendered. Services requiring prior authorization are not eligible for reimbursement by Texas Children's Health Plan if authorization is not obtained and cannot be billed to the member. The decision to render medical services lies with the member and the treating provider.

An authorization should not be considered a guarantee of payment. Payment depends on a number of factors including the beneficiary's eligibility for coverage under the health plan, the health plan's limitations and the coordination of benefits with other plans. Please contact Texas Children's Health Plan at 1-866-959-2555 (STAR) or 1-866-959-6555 (CHIP) for questions about benefit coverage or payment.

Inpatient Authorization and Levels of Care

Texas Children's Health Plan's Utilization Management Department performs timely review of hospital stays and communicates authorization status to the requesting facility within contractual requirements.

Inpatient hospital services must be medically necessary and are subject to utilization review requirements. Outpatient observation services are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Level of care appeals received after claims submission are considered payment disputes and are processed per Texas Children's Health Plan's Claim policies.

Medically Necessary Services

Medically necessary means:

1. For Medicaid members, birth through age twenty (20), the following Texas Health Steps (THSteps) services:
 - a. Screening, vision and hearing services.
 - b. Other health care services necessary to correct or ameliorate a defect or physical or mental illness or condition; a determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
 - i. Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid Managed Care Program as a whole.
 - ii. May include consideration of other relevant factors, such as the criteria described in parts 2)(b-g) and 3)(b-g) of this paragraph.
2. For Medicaid members over age twenty (20) and CHIP members, non-behavioral health-related health care services that are:
 - a. Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member or endanger life.
 - b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
 - c. Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies.
 - d. Consistent with the member's diagnoses.
 - e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency.
 - f. Not experimental or investigative.
 - g. Not primarily for the convenience of the member or provider.

SECTION X. CARE MANAGEMENT

3. For Medicaid members over age twenty (20) and CHIP members, behavioral health services that:
 - a. 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.
 - b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
 - c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
 - d. Are the most appropriate level or supply of service that can safely be provided.
 - e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
 - f. Are not experimental or investigative.
 - g. Are not primarily for the convenience of the member or provider.

Texas Children's Health Plan provides medically necessary and appropriate covered services to all members beginning on the member's date of enrollment, regardless of preexisting conditions, prior diagnosis and/or receipt of any prior health care services.

Medical Necessity Criteria

Texas Children's Health Plan uses written criteria based on clinical evidence in addition to a review of individual circumstances and local health system structure when determining medical appropriateness of health care services. Medical necessity criteria are available on Texas Children's Health Plan's Provider Portal at [texaschildrenshealthplan.org/for-providers](https://www.texaschildrenshealthplan.org/for-providers). Providers may also request a copy of the criteria by calling Texas Children's Health Plan's Provider Hotline at 1-800-731-8527.

CARE MANAGEMENT

Care management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs, using communication and available resources to promote quality, cost-effective outcomes. Care management is a member-centered, goal-oriented and culturally relevant process. This helps to ensure a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Care Management Process

All Texas Children's Health Plan members with identified needs are assessed for care management enrollment. Members with needs may be identified through a variety of means including but not limited to clinical rounds, referrals from Texas Children's Health Plan staff, claims and direct referral from providers or self-referral.

Texas Children's Health Plan's Care Management program contains the following elements:

- Performing outreach to members for enrollment in care management services when identified through the through the above referenced methods. .
- Developing and implementing a care plan that accommodates the specific cultural and linguistic needs of the member.
- Establishing care plan objectives and monitoring care, service and outcomes.
- Referring and assisting the member in ensuring timely access to providers.
- Coordinating medical, residential, social and other support services.
- Revising the care plan as necessary.
- Assessing the member's satisfaction with complex case.
- Measuring the program's effectiveness.

In order to refer a member for enrollment in the Texas Children's Health Plan Care Management Program, contact the Care Management Department at 832-828-1430.

SECTION X. CARE MANAGEMENT

Care Management as Provider Support

Texas Children's Health Plan's Care Management Department supports providers by tracking compliance with the care management plan and facilitating communication between the Primary Care Provider (PCP), member, managing physician and the Care Management team. The case manager also facilitates referrals and links to community providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Texas Children's Health Plan case manager will collaborate with the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Texas Children's Health Plan will provide complex care management for members who have high risk, high cost, complex or catastrophic conditions. The Texas Children's Health Plan case manager will work with all involved providers to coordinate care, provide referral assistance and other care coordination as required. The Texas Children's Health Plan case manager may also assist with a member's transition to other care, as indicated, when the member's benefits end.

Types of Care Management

Texas Children's Health Plan case managers work with the member to create a customizable plan of care in order to promote appropriate cost-effective care as well as adherence to case management plans. Texas Children's Health Plan offers case/disease management programs for, but not limited to, the following conditions:

- Asthma.
- Women's health.
- Obesity.
- Diabetes.
- Transitional care.
- Complex case management.
- Major Depressive Disorder.
- Attention Deficit Hyperactivity Disorder (ADHD).

In addition to case management, Texas Children's Health Plan also offers group education classes on a variety of specific health-related topics. Contact Texas Children's Health Plan's Care Management Department to determine what is available in your area.

SECTION XI. DENIALS & APPEALS

Texas Children's Health Plan's Utilization Management program outlines the process the member, a member's authorized representative or a provider must follow when a covered service is denied. A denial or reduction of services, called an action (STAR) or adverse determination (CHIP), is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.

DENIALS AND APPEALS

No Retaliation

Texas Children's Health Plan will not retaliate against a provider for filing a complaint against the health plan or appealing a decision made by the health plan on behalf of a member.

Medicaid (STAR) Member Notices of Action (Denials)

Texas Children's Health Plan must notify members and providers when it takes an action. An action includes the denial or limited authorization of a requested service, including the type or level of service, the reduction, suspension or termination of a previously authorized service. Only the Texas Children's Health Plan Medical Director, an Associate Medical Director or Physician Reviewer may render a denial for lack of medical necessity (adverse determination).

CHIP Adverse Determinations

A denial is issued when medical necessity cannot be determined for a requested service or if the requested service is determined to be experimental or investigational. Only the Texas Children's Health Plan Medical Director, an Associate Medical Director or Physician Reviewer may render an adverse determination. Prior to issuing an adverse determination, providers will be notified by telephone and/or fax of the pending denial and offered the opportunity to submit additional clinical information or to discuss the member's case with the Medical Director or Physician Designee.

If the member or the member's representative disagrees with a Utilization Management decision, they have the right to access Texas Children's Health Plan Medical Necessity Appeal Process. CHIP members do not have to exhaust Texas Children's Health Plan's internal appeals process before requesting an external review by Maximus.

Peer-To-Peer Discussion

A peer-to-peer discussion is available to the clinical provider ordering the service or supply at any time during the prior authorization, denial or appeal

process. For CHIP members, the opportunity for a peer-to-peer discussion will be offered prior to issuing an adverse determination. For STAR members, a peer-to-peer discussion will be offered before an adverse determination is rendered. To schedule a peer-to-peer discussion of the denial, the referring physician may contact Texas Children's Health Plan at 1-877-213-5508, option 3.

MEDICAID (STAR) MEMBER APPEALS

Medicaid (STAR) Member Standard Appeal

A STAR member can request an appeal of a denial upon receipt of notification of a service denial. If Texas Children's Health Plan denies some but not all of the services requested, the member may ask for an appeal for those services being denied in whole or in part. A member may ask for an appeal by calling Texas Children's Health Plan's Member Services Department at 832-828-1001 or toll free at 1-866-959-2555. Members can also ask for an appeal in writing by mailing a request to:

Texas Children's Health Plan
Attention: Utilization Management Appeals
Department WLS 8390
P.O. Box 301011
Houston, TX 77230-1011

When Texas Children's Health Plan denies or limits a covered benefit (action), the member or his or her authorized representative may file an appeal within 60 days from receipt of the Notice of Action. The member may request that any person or entity act on his or her behalf with the member's written consent. A health care provider may be an authorized representative. A representative from Texas Children's Health Plan can assist the member in understanding and using the appeal process. A Texas Children's Health Plan representative can also assist the member in writing or filing an appeal and monitoring the appeal through the process until the issue is resolved.

Within five (5) business days of receipt of the appeal request, Texas Children's Health Plan will send a letter acknowledging receipt of the appeal request. The member may continue receiving services during the appeal if the appeal is filed within ten (10) business days of the Notice of Action or prior to the effective date of the denial, whichever is later. The member is advised in writing that he or she may have to pay for the services if the denial is upheld. If the appeal

SECTION XI. DENIALS & APPEALS

resolution reverses the denial, Texas Children's Health Plan will promptly authorize coverage.

The Standard Appeal Process must be completed within thirty (30) calendar days after receipt of the initial request for appeal. The timeframe for a standard appeal may be extended for a period of up to fourteen (14) calendar days if the member or his or her representative requests an extension or if Texas Children's Health Plan shows there is need for additional information and how the delay would be in the best interest of the member. Texas Children's Health Plan provides the member or his or her authorized representative with a written notice of the reason for the delay.

Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the member's condition or disease. Texas Children's Health Plan provides a written notice of the appeal determination to the appealing member. If the appeal decision upholds the original decision to deny a service, members receive information regarding their right to request an external review (state fair hearing). The member may request a State Fair Hearing after the health plan's appeal process is complete.

Texas Children's Health Plan's Member Services Department can assist the member with filing an appeal. Contact the Texas Children's Health Plan Member Services Department by calling 832-828-1001 or toll free at 1-866-959-2555.

Medicaid (STAR) Member Expedited Appeal

An expedited appeal can be requested orally by calling the Texas Children's Health Plan Member Services Department at 832-828-1001 or toll free at 1-866-959-2555 or in writing by mailing a request to:

Texas Children's Health Plan
Attention: Utilization Management Appeals
Department WLS 8390
P.O. Box 301011
Houston, TX 77230-1011

STAR members or their authorized representatives may request an expedited appeal either orally or in writing within thirty (30) days (or within ten (10) business days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed

action. A representative from the health plan can assist the member in understanding and using the appeal process. The health plan representative can also assist the member in writing or filing an appeal and monitoring the health plan appeal through the process until the issue is resolved.

If Texas Children's Health Plan denies a request for an expedited appeal, the health plan transfers the appeal to the standard appeal process, makes a reasonable effort to give the appealing member prompt oral notice of the denial and follows up within two (2) calendar days with a written notice. Investigation and resolution of expedited appeals relating to an ongoing emergency or denial of a continued hospitalization are completed (1) in accordance with the medical or dental immediacy of the case and (2) not later than one (1) business day after receiving the member's request for expedited appeal.

Except for an expedited appeal relating to an ongoing emergency or denial of continued hospitalization, the time period for notification to the appealing member of the appeal resolution may be extended up to fourteen (14) calendar days if the member requests an extension or Texas Children's Health Plan shows that there is a need for additional information and how the delay is in the member's best interest. If the timeframe is extended, Texas Children's Health Plan will provide the member with a written notice for the delay if the member had not requested the delay.

When the timeframe is extended by the member, the health plan sends a letter acknowledging receipt of the expedited appeal request and the request for an extension. An individual who was not involved in the original review or decision to deny and is a health care professional with appropriate clinical expertise in treating the member's condition or disease renders the appeal determination. Texas Children's Health Plan provides the appealing member a written notice of the appeal resolution. If the appeal decision upholds the original decision to deny a service, members receive information regarding their right to request an external review (state fair hearing).

Texas Children's Health Plan's Member Services Department has member advocates who can assist the member with filing an appeal whether it be expedited or standard. Contact the Texas Children's Health Plan Member Services Department by calling

SECTION XI. DENIALS & APPEALS

832- 828-1001 or toll free at 1-866-959-2555.

Can a Member ask for a State Fair Hearing?

If a Member, as a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at the following address:

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

or call Texas Children's Health Plan at 832-828-1001 or toll free at 1-866-959-2555.

If the Member asks for a State 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, based on previously authorized services, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State 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.

Member's option to request only a State Fair Hearing, no later than 120 days after Texas Children's Health Plan mails the appeal decision notice at any time during or after the Texas Children's Health Plan's Appeals process.

Medicaid (STAR) Members Access to Expedited State Fair Hearing

STAR members, or their authorized representatives, may request an expedited state fair hearing if they believe that waiting for a standard state fair hearing could seriously jeopardize the member's life or health. In order to qualify for an expedited state fair hearing, the member must first complete Texas Children's Health Plan's expedited appeal process.

An expedited state fair hearing may be requested by calling Texas Children's Health Plan at 832-828-1001 or toll free at 1-866-959-2555. Members can also submit a request for an expedited state fair hearing by completing the State Fair Hearing Form provided with the denial letter, attaching the denial letter or the appeal resolution letter, and sending it to the following address:

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

SECTION XI. DENIALS & APPEALS

CHIP MEMBER APPEALS

CHIP Medical Necessity Appeals – First Level Appeal

Texas Children's Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests. Appeals are reviewed by a physician not involved in the original adverse determination. Texas Children's Health Plan informs the member, the provider requesting the service and the service provider of appeal rights, including how to access expedited and External Review appeals processes at the time a service is denied. The member, the member's representative or the member's health care provider may appeal an adverse determination (medical necessity denial) by calling 832-828-1002 or toll-free at 1-866-959-6555 or by mailing a request to:

Texas Children's Health Plan
Attention: Utilization Management Appeals
Department
P O Box 301011, WLS 8390
Houston, TX 77230

Within five (5) business days from receipt of an appeal, a letter acknowledging the date that the appeal was received is sent to the appealing member. Standard appeals resolutions are resolved and communicated to the appealing member no later than thirty (30) calendar days from receipt of the appeal.

CHIP Specialty Review – Second Level Appeal

A second level of appeal is available to the physician requesting the denied service. The provider may request a specialty review in writing by mailing a request to:

Texas Children's Health Plan
Attention: Utilization Management Appeals
Department
P O Box 301011, WLS 8390
Houston, TX 77230

A request for a specialty review must be submitted within ten (10) business days of receipt of the first level appeal resolution upholding the denial. A provider in the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion and not involved in previous determinations will review the adverse determination. Specialty review is completed within fifteen (15) business days of receipt of the appeal request.

CHIP Member Expedited Appeal Process

A CHIP member, the member's representative or the member's health care provider may request an expedited appeal of an adverse determination if waiting thirty (30) calendar days for a standard resolution could seriously jeopardize the member's life or health. Requests for expedited appeals can be made by calling 832-828-1002 or toll free at 1-866-959-6555 or in writing by mailing a request to:

Texas Children's Health Plan
Attention: Utilization Management Appeals
Department
P O Box 301011, WLS 8390
Houston, TX 77230

If Texas Children's Health Plan denies a request for an expedited appeal, the appeal request will follow the first level appeal process as described above in Medical Necessity Appeals. Investigation and resolution of appeals relating to presently occurring emergency care for life-threatening conditions or denials of continued stays for hospitalization follow the expedited appeal process. A provider not involved in previous determinations and in the same or similar specialty as typically manages the medical or specialty condition, procedure or treatment under discussion reviews the adverse determination and all related denial and appeal documentation. Investigation and resolution of expedited appeals are completed based on the medical immediacy of the condition, procedure or treatment but do not exceed one (1) business day from the date all information necessary to complete the appeal is received. The appeal resolution is communicated to the appellant via telephone and in writing.

SECTION XI. DENIALS & APPEALS

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO 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 External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Texas Children's Health Plan by using the address or fax number at the top of the form.;
- Call Texas Children's Health Plan at 832-828-1001 or toll-free at 1-866-959-2555;
- Email Texas Children's Health Plan at TCHPUM@texaschildrens.org, or;

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review

request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing the Member can also request the Independent Review Organization to be present at the State Fair Hearing. The Member can make both of these requests by contacting the Texas Children's Health Plan or HHHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Texas Children's Health Plan. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete Texas Children's Health Plan's internal appeals process.

Can a Member request an External Medical Review and State Fair Hearing?

Member's option to request an External Medical Review and State Fair Hearing no later than 120 Days after Texas Children's Health Plan mails the appeal decision notice.

SECTION XII. QUALITY IMPROVEMENT PROGRAM

The purpose of Texas Children's Health Plan's Quality Improvement Program is to assure that attributes of care such as accessibility, quality, effectiveness and cost are measured in order to provide feedback to physicians, other providers and members so that Texas Children's Health Plan can influence the quality of health care services provided to our members. The Quality Improvement Program also evaluates non-clinical services that influence member and provider satisfaction with Texas Children's Health Plan.

QUALITY COMMITTEE

Texas Children's Health Plan's Quality Committee reviews the performance of the Quality Improvement Program using performance data obtained from internal and external sources based on a reporting calendar. The scope of monitoring includes health plan performance and clinical and service performance in institutional and non-institutional settings, primary care and major specialty services including mental health care. The method and frequency of data collection are defined for each indicator. The integrity of the data is protected to ensure its validity, reliability, accuracy and confidentiality. Specific goals and data collection sources are standardized throughout Texas Children's Health Plan whenever possible and include but are not limited to the following areas:

- Continuous quality management indicators.
- Member safety.
- Focused studies.
- Performance improvement projects.
- Clinical practice guideline development, adoption and annual review and update.
- Service accessibility assessments.
- Drug and biological utilization data.
- Physician profiling reports.
- Quality of care occurrence reports.
- Member satisfaction surveys.
- Member services performance.
- Medical record and office site visit reviews.
- Credentialing and re-credentialing.
- Provider satisfaction surveys.
- Delegation audit reports.
- Results of quality management improvement plans.

CLINICAL AND ADMINISTRATIVE ADVISORY COMMITTEES

Texas Children's Health Plan's Clinical and Administrative Advisory Committees (CAAC) are subcommittees of the Quality Committee. The Clinical and Administrative Advisory Committees provide recommendations and assistance in the following areas:

- Development, review and revision of clinical practice guidelines.
- Review of general clinical practice patterns and assessment of provider compliance with clinical guidelines.
- Development of quality improvement strategies and studies in coordination with Texas Children's Health Plan, Texas Health and Human Services Commission (HHSC) and the External Quality Review Organization (EQRO).
- Strategies and recommendations for improving Texas Children's Health Plan's administrative procedures.
- Recommendations on how to improve care based on member feedback and their personal experiences serving our members.
- Opportunities for connecting network providers and Texas Children's Health Plan's clinical experts for purposes of peer support and sharing best practices.

CLINICAL PRACTICE GUIDELINES

Texas Children's Health Plan relies on the use of evidence-based clinical practice and medical necessity guidelines to evaluate the quality of care and to identify opportunities for clinical improvement. The clinical practice guidelines are updated at least once every two years. These guidelines are adapted from national guidelines for practice. All are reviewed, modified if appropriate and approved by participating providers and the Texas Children's Health Plan Medical Advisory Committees and Quality Committee, which are composed of primary care physicians and a variety of specialists. Clinical practice guidelines are located on our Provider Portal at [texaschildrenshealthplan.org/for-providers](http://www.texaschildrenshealthplan.org/for-providers), and on our website at <http://www.tchp.us/for-providers/provider-resources/practice-guidelines>.

We will fax or mail the clinical practice guidelines to providers without internet access upon request. Please contact Provider Relations at 832-828-1004 or toll free at 800-731-8527.

SECTION XII. QUALITY IMPROVEMENT PROGRAM

QUALITY IMPROVEMENT FOCUS STUDIES

Texas Children's Health Plan is required to conduct at least two (2) focus studies per year based on state requirements. Texas Children's Health Plan utilizes national standards for the creation of focus studies for clinical and non-clinical services, cost and utilization, and effectiveness of care. Each year Texas Children's Health Plan evaluates the effectiveness of its Quality Improvement Program based on standards for service and quality of care established by the National Committee for Quality Assurance (NCQA).

UTILIZATION MANAGEMENT REPORTING REQUIREMENTS

The primary responsibility for monitoring appropriate use of health services is vested with Texas Children's Health Plan's Medical Director. The Medical Director will establish Utilization Management requirements that may be revised from time to time to assure the delivery of quality care in a cost-effective manner. The Medical Director will be assisted by Registered Nurse Case Managers who will act on behalf of the Medical Director in communicating with participating providers.

PARTICIPATION IN THE QUALITY IMPROVEMENT PROGRAM

There are several ways that providers can participate in Texas Children's Health Plan's Quality Improvement Program. You can participate by:

- Volunteering for committee service.
- Being vocal.
- Responding to surveys and requests for information.

For more information on how to participate in the Quality Improvement Program, contact your assigned Provider Relations Liaison or call 832-828-1004 or 1-800-731-8527.

SECTION XIII. COMPLAINT PROCEDURES

PROVIDER COMPLAINT PROCESS

Texas Children's Health Plan recognizes that there are times when you may not be satisfied with a matter handled by Texas Children's Health Plan. Providers have the right to file a complaint related to that matter. This section describes in detail the process to file a complaint, the response timeframes and the complainant's rights during the process.

The complaint process does not include appeals for determinations/actions based on medical necessity.

Medicaid (STAR) Provider Complaint Process to Texas Children's Health Plan

A complaint is defined as an expression of dissatisfaction communicated by a complainant, orally or in writing, about any matter related to Texas Children's Health Plan, other than an action/adverse determination.

Providers who wish to file a complaint about Texas Children's Health Plan or one of our members can do so by submitting their complaint in writing. Upon receipt of the complaint, the health plan will send an acknowledgement letter to the provider within five (5) business days. Texas Children's Health Plan will respond to all provider complaints within thirty (30) calendar days of receiving the complaint. Texas Children's Health Plan will maintain documentation on each complaint until ten (10) years after the termination of the contract with Texas Health and Human Services Commission (HHSC).

Texas Children's Health Plan offers a number of ways to file a complaint:

- Online through Texas Children's Health Plan's Provider Portal at [texaschildrenshealthplan.org/for-providers](https://www.texaschildrenshealthplan.org/for-providers).
- Emailing a complaint to the Provider Concern email box at tchpproviderconcerns@texaschildrens.org.
- Mailing or faxing a written complaint to the following:
Texas Children's Health Plan
Attention: Provider Complaint Resolution
WLS 8308
P.O. Box 301011
Houston, TX 77230-1011
Fax: 832-825-8750
- Calling Provider Relations at 832-828-1004 or toll-free at 1-800-731-8527.

Medicaid (STAR) Provider Complaint Process to Texas Health and Human Services Commission

If the provider is not happy with the complaint resolution, they have the right to file a complaint with Texas HHSC. When filing a complaint with Texas HHSC, providers must send a letter within sixty (60) calendar days of receiving Texas Children's Health Plan's resolution letter. The letter must explain the specific reasons you believe Texas Children's Health Plan complaint resolution is incorrect. The complaint should include:

- All correspondence and documentation sent to Texas Children's Health Plan, including copies of supporting documentation submitted during the complaint process.
- All correspondence and documentation you received from Texas Children's Health Plan.
- All remittance and status reports of the claims/services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable.
- Provider internal notes and logs when pertinent.
- Memos from the state or health plan indicating any problems, policy changes or claims processing discrepancies that may be relevant to the complaint.
- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

When filing a complaint with Texas HHSC, providers must submit a letter to the following address:

Texas Health and Human Services Commission
Medicaid/CHIP Health Plan Management
Mail Code H-320
P.O. Box 85200
4900 N. Lamar
Austin, TX 78708-5200

SECTION XIII. COMPLAINT PROCEDURES

CHIP Provider Complaint Process to Texas Children's Health Plan

A complaint is defined as any dissatisfaction, expressed by a complainant, orally or in writing, with any aspect of Texas Children's Health Plan's operation.

Providers who wish to file a complaint about Texas Children's Health Plan or one of our members can do so by submitting their complaint in writing. Upon receipt of the complaint, Texas Children's Health Plan will send an acknowledgement letter to the provider within five (5) business days. Texas Children's Health Plan will respond to all provider complaints within thirty (30) calendar days of receiving the complaint. Texas Children's Health Plan will maintain documentation on each complaint until ten (10) years after the termination of the contract with Texas Health and Human Services Commission.

Texas Children's Health Plan offers a number of ways to file a complaint:

- Online through Texas Children's Health Plan's Provider Portal at texaschildrenshealthplan.org/for-providers.
- Emailing a complaint to the Provider Concern email box at tchpproviderconcerns@texaschildrens.org.
- Mailing or faxing a written complaint to the following:
Texas Children's Health Plan
Attention: Provider Complaint Resolution
WLS 8308
P.O. Box 301011
Houston, TX 77230-1011
Fax: 832-825-8750
- Calling Provider Relations at 832-828-1004 or toll-free at 1-800-731-8527.

CHIP Provider Complaint Process to Texas Department of Insurance

If the provider is not happy with the complaint resolution, they have the right to file a complaint with the Texas Department of Insurance (TDI). The provider can contact the TDI by calling 1-800-252-3439 or in writing by mailing a request to:

Texas Department of Insurance
Mail Code 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Texas Children's Health Plan is required to comply with the complaint and appeal procedures as defined by the Texas Department of Insurance.

Appealing a Complaint Resolution

Complaint appeals must be submitted no later than thirty (30) days of the resolution/response letter. The appeal will be acknowledged within five (5) business days of receipt and responded to within thirty (30) days of receipt. If the resolution/ response is not satisfactory, a provider may ask that their appeal be reviewed and settled in accordance with the commercial arbitration rules of the American Arbitration Association, or the arbitration or litigation provisions as noted in the individual provider's contract with Texas Children's Health Plan.

Medical Necessity Appeals

The complaint process does not include medical necessity appeals that are directed to Texas Children's Health Plan's Utilization Management. Please refer to the Denials and Appeals section of this Provider Manual for details related to medical necessity denials and appeals.

MEMBER COMPLAINT PROCESS

Texas Children's Health Plan understands that there are times when a member is not satisfied with Texas Children's Health Plan. In those instances, Texas Children's Health Plan affords members their right to file a complaint. This section describes in detail the process to file a complaint, the response timeframes and the complainant's rights during the process.

The complaint process does not include appeals for determinations/actions based on medical necessity.

SECTION XIII. COMPLAINT PROCEDURES

Medicaid (STAR) Member's Right to File Complaints to Texas Children's Health Plan

A complaint is defined as dissatisfaction expressed by a complainant with any aspect of the health plan's operation. A complaint does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to the satisfaction of the complainant.

A STAR member, or the member's authorized representative, has the right to file a complaint either orally or in writing. Texas Children's Health Plan will resolve all complaints within thirty (30) days from the date the complaint is received. If the member needs assistance in filing a complaint, they can contact the Member Services Department and a Member Services Advocate will assist them.

Texas Children's Health Plan offers a number of ways a member can file a complaint:

- Email membercomplaints@texaschildrens.org.
- Filing a complaint in writing to:
Texas Children's Health Plan
Attention: Member Service Complaints
P.O. Box 301011
Houston, TX 77230-1011
- Calling Member Services:
STAR: 832-828-1001 or 1-866-959-2555
CHIP: 832-828-1002 or 1-866-959-6555

Medicaid (STAR) Member's Right to File Complaints to Texas Health and Human Services Commission

If the STAR member is not satisfied with the resolution of the complaint, they may also file a complaint directly with Texas Health and Human Services (HHSC). There are four (4) ways a member can file a complaint with HHSC:

1. Call: 1-866-566-8989 toll-free, 8 a.m.-5 p.m. Monday-Friday. Those with a hearing or speech impairment can call Relay Texas toll-free at 7-1-1 or 1-800-735-2989.
2. Online: Submit an online complaint form by going to <https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-managed-care-help> and clicking on "Complete our online form."

3. Mail:
Texas Health and Human Services Commission
Ombudsman for Managed Care
P.O. Box 13247
Austin, TX 78711-3247

4. Fax: 1-888-780-8099

CHIP Member Complaint Process

A CHIP member or the member's authorized representative who is not satisfied with their health care services can file a complaint with Texas Children's Health Plan. Members should call Member Services at 832-828-1002 or toll free at 1-866-959-6555.

If a member needs assistance with filing a complaint, Texas Children's Health Plan's Member Services can assist the member. The member may also send the complaint in writing to:

Texas Children's Health Plan
Attention: Member Service Complaints
P.O. Box 301011
Houston, TX 77230-1011

Texas Children's Health Plan will send the member a letter within five (5) business days telling them that Texas Children's Health Plan has received their complaint. Texas Children's Health Plan will also include a complaint form with the letter if the complaint was filed orally. Within thirty (30) days of receiving the written complaint, Texas Children's Health Plan will mail the member a letter with the outcome of the complaint. The resolution letter will include an explanation of Texas Children's Health Plan's resolution of the complaint, a statement of the specific medical and contractual reasons for the resolution and the specialization of any physician or other provider consulted. The resolution letter will also contain a full description of the process for an appeal, including the deadlines for the appeal process and the deadlines for the final decision on an appeal.

Texas Children's Health Plan shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical immediacy of the case and not later than one (1) business day after Texas Children's Health Plan receives the complaint.

SECTION XIII. COMPLAINT PROCEDURES

CHIP Member Appeal of Complaint Resolution

If a CHIP member does not like the response to their complaint, they can contact Texas Children's Health Plan and request an appeal by asking for a hearing with the Complaint Appeal Panel. Every oral appeal received must be confirmed by a written, signed appeal by the member or his or her representative, unless the member asks for an expedited appeal. If a member needs assistance with filing an appeal, a Member Services Representative can assist the member.

The member has the right to appear before the Complaint Appeal Panel at a time and place that is acceptable and convenient to the member. The Complaint Appeal Panel is a group of people that includes equal numbers of:

- Texas Children's Health Plan staff.
- Physicians or other providers with experience in the area of care that is in dispute and must be independent of any physician or provider who made the prior determination.
- Enrollees (enrollees may not be Texas Children's Health Plan staff).
- If specialty care is in dispute, the panel must include a specialist in the field of care related to the dispute.

Not later than the fifth (5) business day before the scheduled meeting of the panel, unless the member agrees otherwise, Texas Children's Health Plan will provide to the member or the member's designated representative:

- Any documentation to be presented to the panel by the Texas Children's Health Plan staff.
- The specialization of any physicians or providers consulted during the investigation.
- The name and affiliation of each Texas Children's Health Plan representative on the panel.

The member or designated representative is entitled to:

- Appear in person before the Complaint Appeal Panel.
- Present alternative expert testimony.
- Request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

Appeals relating to ongoing emergencies or denials of continued stays for hospitalization will be completed in accordance with the medical immediacy of the case but in no event to exceed one (1) business day after the request for appeal is received. At the request of the member, Texas Children's Health Plan shall provide, in lieu of a Complaint Appeal Panel, a review by a specialist of the same or similar specialty as the physician or provider who would typically manage the medical condition, procedure or treatment and who has not previously reviewed the case. The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide on the appeal. Initial notice of the decision may be delivered orally if followed by written notice not later than three (3) days after the date of the decision.

The Complaint Appeal Panel only serves in an advisory role to Texas Children's Health Plan. Texas Children's Health Plan will consider the findings of the panel and render a final decision. The appeals process must be completed not later than thirty (30) calendar days after receipt of the written request for appeal.

CHIP Member Right to File Complaints with Texas Department of Insurance

If the CHIP member is not satisfied with the outcome of Texas Children's Health Plan's appeal process, they can file a complaint with the Texas Department of Insurance (TDI). The member can contact TDI by calling toll free 1-800-252-3439 or in writing by mailing a request to:

Consumer Protection, Mail Code 111-1A
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

A CHIP member can also submit their complaint online at tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.

SECTION XIV. COMMUNITY FIRST CHOICE

PROGRAM PROVIDER RESPONSIBILITIES

- The Community First Choice (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 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.

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SECTION XV. APPENDIX

ATTACHMENT A – PRIMARY CARE BY SPECIALIST REQUEST FORM



**Texas Children's
Health Plan**

The best decision a family can make.

Primary Care by Specialist Request Form

Member's name: _____

Date of birth: _____ Member number: _____

Parent/guardian's name: _____

Primary HMO: _____

Primary care physician 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.

Signature, 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.

Signature, Specialist

Date signed

Specialist telephone number: _____

Fax to Texas Children's Health Plan at 832-825-8750

Date received: _____ Date notified of decision: _____

Review by Medical Director

Approved Denied

List reason:

Signature, Medical Director

Date signed

ND-0613-106

SECTION XV. APPENDIX

ATTACHMENT B – TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES



Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115

Texas Department of Insurance

Please read all instructions below before completing this form.

*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization **by fax or mail**. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.

If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

SECTION XV. APPENDIX

ATTACHMENT B – TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
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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

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (<i>Medicaid only</i> : Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

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

An issuer needing more information may call the requesting provider directly at: _____

SECTION XV. APPENDIX

ATTACHMENT C – PROVIDER INFORMATION CHANGE FORM



Provider Information Change Form

Please print clearly or type all of the information on this form. Mail, fax, or email the completed form and any additional documentation to the address, fax number, or email address at the bottom of the page. **Include W9 in the submission.**

Check the box if the changes are for a PCP Provider with TCHP Date: _____

National Provider Identifier (NPI): _____ Provider Name: _____

Tax Identification Number (TIN): _____ Office Manager Name: _____

Name of Person filling out form: _____ Office Phone Number: _____

Type of Change Request (check all that apply) **Address change must reflect attested NPI address.**

Change of physical address, telephone, and/or fax number

Change of billing/mailling address and/or Tax Information Number (TIN)

Change/add secondary or additional addresses, telephone, and/or fax number

Change of provider status (e.g., panel closing, capacity changes, and age acceptance)

Change in hospital affiliation Y N Describe change _____

Other (Explain) _____

Physical Address – The physical address cannot be a PO Box. ADA Compliant? Y N

Clinic Name: _____ Effective Date: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax Number: _____ Email: _____

Secondary Address ADA Compliant? Y N

Clinic Name: _____ Effective Date: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax Number: _____ Email: _____

Additional Address ADA Compliant? Y N

Clinic Name: _____ Effective Date: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax Number: _____ Email: _____

Tax Information – Tax Identification Number (TIN) and Name for the Internal Revenue Service (IRS)

Tax ID Number: _____ Effective Date: _____

Exact name reported to the IRS for this Tax ID: _____

Billing/Mailing Address – All providers who make changes to the Billing/Mailing address must submit a copy of the W9 Form along with this form.

Street Address or Post Office: _____ City: _____ State: _____ Zip Code: _____

REQUIRED FIELD – Billing Address Effective Date: _____

Other Provider Demographic Information – (fill out only if changes are required)

Languages spoken other than English: _____

Provider office hours by location: _____

Panel Status: STAR CHIP Both Accepting (check one): New Patients Current Patients Only Effective Date: _____

Patient age range accepted by provider: _____ Patient gender limitations: Female Male Both

Telehealth Telemedicine Telemonitoring

Comments: _____

REQUIRED FIELD – SIGNATURE AND DATE ARE REQUIRED OR THE FORM WILL NOT BE PROCESSED.

Provider or Requestor signature: _____

Mail, fax, or email the completed form to: Texas Children's Health Plan
 Provider Relations Dept.
 PO Box 301011 WLS 8301
 Houston, TX 77230-1011
 Fax: 832-825-8750
 Email: providerrelations@texaschildrens.org

If you have any questions or concerns regarding this form, please do not hesitate to contact your Provider Relations Liaison or the Provider Relations Dept. at 832-828-1008. Thank you for being a provider with Texas Children's Health Plan.

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SECTION XV. APPENDIX

ATTACHMENT D – MEMBER ID CARDS

STAR

STAR MEMBER ID CARD

Name:
DOB:
ID:
Group:
PCP Name:
PCP Effective Date:
PCP Phone:
RXBIN: 610602 RXPCN: MCD RXGRP: TCH

Texas Children's Health Plan Member Services 24/7
 Servicios para Miembros de Texas Children's Health Plan 24/7 **1-866-959-2555**
Service Coordination Coordinación de servicios **1-800-659-5764**
Nurse Help Line 24/7 Línea telefónica de enfermería 24/7 . . . **1-800-686-3831 (TDD): 1-800-735-2989**
Behavioral Health & Substance Abuse Line 24/7
 Línea telefónica de salud mental y abuso de sustancias 24/7 **1-800-731-8528**
Vision Care Cuidado de la visión **Enroll Vision: 1-844-520-3711**
Transportation Help Ayuda de transporte **Veyo: 1-888-401-0170**
Pharmacy Benefit Manager Administrador de beneficios de farmacia **Navitus: 1-877-908-6023**

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.
 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.

Texas Children's Health Plan
PO Box 300286, Houston, TX 77230-0286
 File all claims directly to the above address.
 Electronic Claims Filing Number: 76048

This non-transferable card is for identification; it does not guarantee coverage.

texaschildrenshealthplan.org
 MS-2105-203

CHIP

CHIP MEMBER ID CARD

Name:	Copays:
DOB:	OV \$
ID:	Non-ER \$
Group:	Inpatient \$
PCP Name:	
PCP Effective Date:	RX:
PCP Phone:	Generic \$
RXBIN: 610602 RXPCN: MCD RXGRP: TCH	Brand \$

Texas Children's Health Plan Member Services 24/7
 Servicios para Miembros de Texas Children's Health Plan 24/7 **1-866-959-6555**
Nurse Help Line 24/7 Línea telefónica de enfermería 24/7 . . . **1-800-686-3831 (TDD): 1-800-735-2989**
Behavioral Health & Substance Abuse Line 24/7
 Línea telefónica de salud mental y abuso de sustancias 24/7 **1-800-731-8528**
Vision Care Cuidado de la visión **Enroll Vision: 1-844-520-3711**
Transportation Help Ayuda de transporte **Veyo: 1-888-401-0170**
Pharmacy Benefit Manager Administrador de beneficios de farmacia **Navitus: 1-877-908-6023**

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.
 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.

Texas Children's Health Plan
PO Box 300286, Houston, TX 77230-0286
 File all claims directly to the above address.
 Electronic Claims Filing Number: 76048

This non-transferable card is for identification; it does not guarantee coverage.

texaschildrenshealthplan.org
 MS-2105-200

CHIP Perinate

CHIP PERINATE UNBORN MEMBER ID CARD

Name:	Hospital Facility Billing:
DOB:	FPL Group A: Bill TMHP
ID:	FPL Group B: Bill Texas Children's Health Plan
Group:	
Effective Date:	
FPL Group: filler1	
RXBIN: 610602 RXPCN: MCD RXGRP: TCH	

Texas Children's Health Plan Member Services 24/7
 Servicios para Miembros de Texas Children's Health Plan 24/7 **1-866-959-6555**
Nurse Help Line 24/7 Línea telefónica de enfermería 24/7 . . . **1-800-686-3831 (TDD): 1-800-735-2989**
Behavioral Health & Substance Abuse Line 24/7
 Línea telefónica de salud mental y abuso de sustancias 24/7 **1-800-731-8528**
Vision Care Cuidado de la visión **Enroll Vision: 1-844-520-3711**
Transportation Help Ayuda de transporte **Veyo: 1-888-401-0170**
Pharmacy Benefit Manager Administrador de beneficios de farmacia **Navitus: 1-877-908-6023**

In case of emergency, call 911 or go to the closest emergency room.
 En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

Texas Children's Health Plan
PO Box 300286, Houston, TX 77230-0286
 File all claims directly to the above address.
 Electronic Claims Filing Number: 76048

This non-transferable card is for identification; it does not guarantee coverage.

texaschildrenshealthplan.org
 MS-2105-202

SECTION XV. APPENDIX
ATTACHMENT E – CLAIM APPEAL FORM



Texas Children's[®]
Health Plan

The best decision a family can make.

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

SECTION XV. APPENDIX

ATTACHMENT F – MEMBER ACKNOWLEDGEMENT STATEMENT

English

"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."

Name: _____

Date: _____

Spanish

"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."

Nombre: _____

Fecha: _____

SECTION XV. APPENDIX

ATTACHMENT G – PRIVATE PAY STATEMENT

English

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: _____

Spanish

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: _____



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832-828-1004 or toll-free 1-800-731-8527

