



Texas Children's[®] Health Plan

Texas Children's Health Plan Provider Manual



STAR Kid's service areas

Harris

Austin
Brazoria
Fort Bend
Galveston
Harris
Matagorda
Montgomery
Waller
Wharton

Jefferson

Chambers
Hardin
Jasper
Jefferson
Liberty
Newton
Orange
Polk
San Jacinto

**Walker
Northeast**

Anderson
Angelina
Bowie
Camp
Cass
Cherokee
Cooke
Delta

Fannin
Franklin
Grayson
Gregg
Harrison
Henderson
Hopkins
Houston
Lamar
Marion

Montague
Morris
Nacogdoches
Panola
Rains
Red River
Rusk
Sabina
San Augustine
Shelby

Smith
Titus
Trinity
Tyler
Upshur
Van Zandt
Washington
Wood

texaschildrenshealthplan.org
832-828-1008 or toll-free 1-800-731-8527



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, Texas Children's® Link
- Request for educational in-services, CME, and educational material
- Concerns with Texas Children's Health Plan Policies and Procedures

Phone 832-828-1008
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

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 832-828-1008
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® Link

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

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

Post Hospital Discharge Authorizations

Fax Line – Toll-Free 866-839-9879

Behavioral Health/Substance Abuse Hotline

STAR Kids 1-844-818-0125

Vision Services

Envolve Vision
STAR Kids 1-844-212-7269

Dental Services

DentaQuest 1-800-516-0165
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

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

CONTENTS

Contents

PROVIDER QUICK REFERENCE GUIDE 1

SECTION I. INTRODUCTION 7

BACKGROUND 7

STAR KIDS PROGRAM AND OBJECTIVES 7

ROLE OF A PRIMARY CARE PROVIDER
(MEDICAL HOME) 7

PRACTICE AREAS 7

ROLE OF A MEDICAL HOME/HEALTH HOME 8

ROLE OF A SPECIALTY CARE PROVIDER 8

ROLE OF LONG TERM SERVICES AND SUPPORTS
(LTSS) PROVIDERS 9

ROLE OF TEXAS CHILDREN'S HEALTH PLAN
SERVICE COORDINATOR 9

ROLE OF A TEXAS CHILDREN'S HEALTH PLAN
TRANSITION SPECIALIST 9

ROLE OF PHARMACY 10

ROLE OF MAIN DENTAL HOME 10

NETWORK LIMITATIONS 10

CREDENTIALING AND RE-CREDENTIALING 11

SECTION II. DEFINITIONS 13

1915(I) HOME AND COMMUNITY BASED
SERVICES—ADULT MENTAL HEALTH (HCBS-AMH) 13

COMMUNITY LIVING ASSISTANCE AND
SUPPORT SERVICES (CLASS) WAIVER PROGRAM 13

DEAF BLIND WITH MULTIPLE DISABILITIES (DBMD)
WAIVER PROGRAM 13

DUAL-ELIGIBLE 13

HOME AND COMMUNITY-BASED SERVICES
(HCS) WAIVER PROGRAM 13

LONG TERM SERVICES AND SUPPORTS (LTSS) 13

MEDICAL DEPENDENT CHILDREN PROGRAM
(MDCP) WAIVER PROGRAM 13

TEXAS HOME LIVING (TXHML)
WAIVER PROGRAM 13

YOUTH EMPOWERMENT SERVICES
(YES) WAIVER PROGRAM 13

SECTION III. COVERED SERVICES 14

TEXAS HEALTH STEPS SERVICES 14

*Documentation of completed Texas Health
Steps components and elements 14*

Children of Migrant Farmworkers 15

*Description of Long Term Services and
Support Services (LTSS) 15*

SERVICE COORDINATION SERVICES 17

*Role of a Texas Children's Health Plan
Service Coordinator 17*

STAR Kids Screening and Assessment Instrument 17

STAR Kids Screening and Assessment Process 17

Level 1 Members 18

Level 2 Members 18

Level 3 Members 18

Individual Service Plan 18

Discharge Planning 18

Continuity of Care Transition Plan 18

ADULT TRANSITION PLANNING 18

MDCP/DBMD ESCALATION HELP LINE 19

HEALTHY TEXAS WOMEN PROGRAM 19

HEALTHY TEXAS WOMEN PLUS PROGRAM 20

FAMILY PLANNING PROGRAM 20

CASE MANAGEMENT FOR CHILDREN AND
PREGNANT WOMEN 20

Eligibility 20

PRIMARY HEALTH CARE SERVICES PROGRAM 21

COORDINATION WITH NON-MEDICAID
MANAGED CARE COVERED SERVICES
(NON-CAPITATED SERVICES) 21

Medicaid Non-Capitated Services 21

NON-EMERGENCY MEDICAL TRANSPORTATION
(NEMT) SERVICES 21

BEHAVIORAL HEALTH 22

Definition of Behavioral Health 22

Behavioral Health Covered Services 23

Primary Care Provider Requirements for Behavioral Health 23

Member Access to Behavioral Health Services 23

Attention Deficit Hyperactivity Disorder (ADHD) 23

Health Home 23

Self Referral 24

*Behavioral Health Focus Studies and
Utilization Management Reporting 25*

Behavioral Health Value-Added Services 25

Behavioral Health Emergencies 26

*Substance Use Disorder and Specialized
Service Coordination 26*

*Mental Health Rehabilitative (MHR) Services and
Targeted Case Management (TCM) 26*

Severe and Persistent Mental Illness (SPMI) 27

Severe Emotional Disturbance (SED) 27

Member Access to Benefits of MHR Services and TCM 27

CONTENTS

Provider Requirements	27	Mandatory Challenge Survey	37
COORDINATION OF CARE	27	LONG TERM SERVICES AND SUPPORTS	37
QUALITY MANAGEMENT	28	Community First Choice Provider Responsibilities	37
Clinical Practice Guidelines	28	Employment Assistance	38
Behavioral Health Focus Studies and Utilization Management Reporting	28	Supported Employment	39
SECTION IV. PROVIDER RESPONSIBILITIES . 29		PHARMACY PROVIDER RESPONSIBILITIES	39
PRIMARY CARE PROVIDER RESPONSIBILITIES (MEDICAL HOME RESPONSIBILITIES)	29	COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES	39
Performing Obligations within the United States	29	EMERGENCY, URGENT, AND ROUTINE SERVICES	39
Differences between PCP and Health Home	29	Emergency/Emergency Services	39
Availability and Accessibility	30	Urgent Care Services	40
Acceptable After-hours Coverage	31	Routine Care Services	40
Unacceptable After-hours Coverage	31	REQUIREMENTS FOR SCHEDULING APPOINTMENTS	41
Reporting Updates to Contact Information	31	Availability and Accessibility	41
Plan Termination	31	Emergency Prescription Supply	42
Member Education about Member’s Right to Designate an OB/GYN as their Primary Care	32	Emergency Transportation—Ambulance	42
Specialist Functioning as Primary Care Provider	32	Non-emergency Transportation—Medical Transportation	42
Member Education about Member’s Right to Eye Health Care Services	32	Requesting NEMT Services	42
Members’ Right to Choose a Texas Children’s Health Plan Network Pharmacy	32	Transportation Value-Added Services	43
Member Information about Advance Directives	32	Medicaid Emergency Dental Services	43
Referral to Specialists and Health-related Services	33	Medicaid Non-emergency Dental Services	43
How to Help Member Find Dental Care	33	Durable Medical Equipment and Other Products Normally Found in a Pharmacy	43
Primary Care Provider Requirements for Behavioral Health	33	Durable Medical Equipment /Diabetic Supplies	44
Referral to Network Facilities and Contractors	33	ELECTRONIC VISIT VERIFICATION	44
Members’ Right to a Second Opinion	34	What is Electronic Visit Verification (EVV)?	44
Specialty Care Provider Responsibilities	34	Is there a law that requires the use of EVV	44
Availability and Accessibility	34	Which services must a Service Provider or CDS Employee electronically document and verify using EVV?	44
Responsibility to Verify Member Eligibility and/or Authorizations for Service	35	Who must use EVV?	44
TEXAS CHILDREN’S HEALTH PLAN CONTINUITY OF CARE IN THE FOLLOWING SITUATIONS	35	EVV SYSTEMS	45
Out-of-Network Providers	35	Do Providers and FMSAs have a choice of EVV Systems?	45
For Members active on the Operational Start Date	35	Does a CDS Employer have a choice of EVV Systems?	45
Medical Records	36	What is the process for a Provider or FMSA to select an EVV System?	45
Justification Regarding Out-of-Network Referrals— Including Partners Not Contracted with Texas Children’s Health Plan	36	What requirements must a Provider or FMSA meet before using the selected EVV System?	45
REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE) MEDICAID MANAGED CARE	36	Does a Provider or FMSA pay to use the selected EVV System?	45
Report suspected Abuse, Neglect, and Exploitation	36	Can a Provider or FMSA change EVV Systems?	46
		What is the process to change from one EVV System to another EVV System?	46
		Are the EVV Systems accessible for people with disabilities?	46

CONTENTS

EVV SERVICE AUTHORIZATIONS	46	How to Submit Appeals via Provider Portal	52
<i>What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?</i>	46	Documentation	52
EVV CLOCK IN AND CLOCK OUT METHODS	47	Provider Complaints to Texas Health and Human Services Commission	52
<i>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?</i>	47	Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)	52
<i>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?</i>	48	SECTION VI. MEMBER COMPLAINTS AND APPEALS	54
EVV VISIT MAINTENANCE	48	MEMBER'S RIGHT TO FILE COMPLAINTS WITH TEXAS CHILDREN'S HEALTH PLAN AND HHSC	54
<i>Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?</i>	48	How to File a Complaint	54
<i>Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance.</i>	48	Assistance and Filing Process	54
EVV TRAINING	48	Timeframe for Filing a Complaint	54
<i>What are the EVV training requirements for each EVV System user?</i>	48	Timeframe for Resolution of a Complaint	54
COMPLIANCE REVIEWS	49	Member's Right to Appeal an Action	54
<i>What are EVV Compliance Reviews?</i>	49	HOW TO FILE AN APPEAL	55
EVV CLAIMS	49	Timeframe for Filing an Appeal	55
<i>Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?</i>	49	Timeframe for Resolution of an Appeal	55
<i>Where does a Provider or FMSA submit an EVV claim?</i>	49	Right to an Expedited MCO Appeal	55
<i>What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the Claims Administrator?</i>	49	How to File an Expedited Appeal	55
<i>What happens after the Claims Administrator receives an EVV claim from a Provider or FMSA?</i>	49	Resolution Timeframe for an Expedited MCO Appeal	56
<i>How does the automated EVV claims matching process work?</i>	49	STATE FAIR HEARING INFORMATION	56
<i>How can a Provider and FMSA see the results of the EVV claims matching process?</i>	50	Can a Member ask for a State Fair Hearing?	56
<i>Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?</i>	50	Can a Member ask for an External Medical Review?	56
SECTION V. PROVIDER COMPLAINTS AND APPEALS	51	Can a Member ask for an emergency External Medical Review?	57
PROVIDER COMPLAINTS TO TEXAS CHILDREN'S HEALTH PLAN	51	Can a Member request an External Medical Review and State Fair Hearing?	57
How to Submit Complaints Online	51	SECTION VII. MEMBER ELIGIBILITY AND ADDED BENEFITS	58
How to Submit Complaints via Paper	51	ENROLLMENT	58
Documentation	51	VERIFYING MEMBER MEDICAID ELIGIBILITY AND TEXAS CHILDREN'S HEALTH PLAN ENROLLMENT	58
PROVIDER APPEAL TO TEXAS CHILDREN'S HEALTH PLAN	52	Providers access to Medicaid medical and dental health information	58
How to Submit Appeals via Paper	52	Your Texas Benefits STAR Kids Medicaid Card and STAR Kids Medicaid Verification Form 1027-A	58
		Texas Children's Health Plan Identification Card	59
		Medicare	59
		ADDED BENEFITS	59
		STAR Kids Value-added Services	60
		SECTION VIII. MEMBERS RIGHTS AND RESPONSIBILITIES	61
		MEMBERS RIGHTS	61
		MEMBERS RESPONSIBILITIES	62

CONTENTS

Members Right to Designate an OB/GYN (STAR Kids Dual Eligible Members are excluded.):	62
FRAUDS INFORMATION	62
REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE	62
To report waste, abuse or fraud, choose one of the following.	63
Information needed to report Fraud, Waste, or Abuse.	63
SECTION IX. BILLING AND CLAIM ADMINISTRATION	64
CLAIMS FILING	64
LONG-TERM SERVICES AND SUPPORTS (LTSS) 1915(C) WAIVERS	64
Long-Term Services and Supports (LTSS) not covered by Texas Children’s Health Plan	64
Provider Portal Functionality.	65
Claims Submission Form/Format	65
TCHP Billing Requirements for LTSS Services.	65
Monthly Capitation Services.	65
Emergency Services Claims	65
Coordination of Benefits with Third Party Resources, to include Medicare for Dual Eligible STAR Kids Members	65
Member Acknowledgement Statement	65
Private Pay Agreement Form	66
Time Limit for Submission of Claims	67
Clean Claims Payment for Professional and Institutional Claim Submission	67
Clean Claims Payment on Pharmacy Claim Submission	67
APPROVED CLAIM FORM	68
CLAIMS APPEAL FORM	70
Payment/Accrual of interest by Texas Children’s Health Plan	71
Allowable Billing Methods.	71
Special Billing (Newborns, Value-Added Services, SSI Compounded Medications, etc.)	71
Claims Questions/Appeals	71
How to find a list of covered drugs.	71
How to find a list of preferred drugs	71
Process for Requesting a Prior Authorization (PA)	71
AUTHORIZATION FOR HEALTH SERVICES	71
Medical Authorizations.	71
Behavior Health Authorizations	72
Authorization of Clinician-Directed Care Coordination for Medically Complex Members.	72
How to Find a List of PA Required Services and Codes	72
Prior Authorization Determinations	73
Prior Authorization Fax Lines	73
Provider Portal	73
Continuity of Care and Out of Network Provider Requirements.	73
SECTION X. DISENROLLMENT FROM HEALTH PLAN	76
ENROLLMENT	76
Newborn processs	76
AUTOMATIC RE-ENROLLMENT	76
Changing Health Plans.	76
DISENROLLMENT	76
SECTION XI. SPECIAL ACCESS REQUIREMENTS	77
SPECIAL ACCESS.	77
Interpreter/Translation Services	77
Provider/Care Coordination.	77
Reading /Grade Level Consideration.	77
Cultural Sensitivity	78
Telemedicine, Telehealth, and Telemonitoring Access.	78
SECTION XII. APPENDIX	79
ATTACHMENT A – PRIMARY CARE BY SPECIALIST REQUEST FORM	80
ATTACHMENT B – TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES.	81
ATTACHMENT C – PROVIDER INFORMATION CHANGE FORM	83
ATTACHMENT D – MEMBER ID CARD	84
ATTACHMENT E – CLAIM APPEAL FORM.	85
ATTACHMENT F – MEMBER ACKNOWLEDGEMENT STATEMENT.	86
ATTACHMENT G – PRIVATE PAY STATEMENT	87
ATTACHMENT H – COORDINATION OF CARE REFERRAL FORM.	88

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 Kids 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 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's 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.

Senate Bill 7 from the 83rd Legislature, Regular Session, 2013 required the Texas Health and Human Services Commission (HHSC) to create the State of Texas Access Reform (STAR) Kids program. STAR Kids is a Medicaid managed care program for children with disabilities in Texas, which integrates acute care and long term services and supports (LTSS) delivered by a managed care organization

STAR KIDS PROGRAM AND OBJECTIVES

Senate Bill 71 directs the Health and Human Services Commission to establish a mandatory, capitated STAR Kids managed care program tailored to provide Medicaid benefits to children and young adults with disabilities. Through the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver, STAR Kids will serve children and young adults under the age of 21 who receive Supplemental Social Security Income (SSI) and SSI-related Medicaid. For eligible Members, STAR Kids will also provide the full service array for the Medically Dependent Children Program (MDCP).

The STAR KIDS program is a Medicaid managed care program providing integrated acute and long-term services and supports 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 Health and Human Services Commission (HHSC)).

In addition to the objectives of the STAR program, the STAR Kids program aims to:

- Integrate acute and long-term care services and supports
- Coordinate Medicare services for clients who are dual eligible

ROLE OF A PRIMARY CARE PROVIDER (MEDICAL HOME)

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

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

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

PRACTICE AREAS

Texas Children's Health Plan PCP Network may include Providers from any of the following practice areas:

- General Practice
- Family Practice
- Internal Medicine
- Pediatrics
- Obstetrics/Gynecology (OB/Gyn)
- Advanced Practice Registered Nurses (APRNs)

SECTION I. INTRODUCTION

- Physician Assistants (PAs)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs), and similar community clinics;
- Specialist physicians who are willing to provide a Health Home to selected Members with special needs and conditions

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

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

STAR Kids Members with dual eligibility are not required to have a PCP with Texas Children's Health Plan.

ROLE OF A MEDICAL HOME/ HEALTH HOME

Texas Children's Health plan must provide access to a Health Home to any Member the health plan determines would most benefit from a Health Home or for any Member who requests a Health Home. A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

Health Home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

1. Patient self-management education;
2. Provider education;

3. Patient-centered and family-centered care;
4. Evidence-based models and minimum standards of care; and
5. Patient and family support (including authorized representatives).

Health Home Services may also include:

1. A mechanism to incentivize providers for provision of timely and quality care;
2. Implementation of interventions that address the continuum of care;
3. Mechanisms to modify or change interventions that are not proven effective;
4. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;
5. Comprehensive care coordination and health promotion'
6. Palliative care options in the event of a life-limiting diagnosis;
7. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
8. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;
9. Referral to community and social support services, if relevant; and
10. Use of health information technology to link services, as feasible and appropriate.

ROLE OF A SPECIALTY CARE PROVIDER

The role of the specialty care provider is to meet the medical specialty needs of STAR Kids members and provide all medically necessary covered services. Specialty care providers coordinate care with the member's medical home provider. Specialty care providers include behavioral health providers and other services:

- Provide specialty services upon referral from the primary care provider.
- Work closely with primary care provider to enhance continuity in health services to members.
- Advise the primary care provider in writing regarding findings in a consultation, recommendations or an ongoing treatment program.
- Notify primary care provider if another specialist is needed.

SECTION I. INTRODUCTION

- Notify the primary care provider and Texas Children's Health Plan when a specialist wishes to admit a member to a hospital and provide information necessary to authorize the admission. Texas Children's Health Plan does not require pre-authorization for in-network specialists to treat members.

Member eligibility may be confirmed by calling Member Services at **832-828-1008** or toll free **1-800-731-8527** or online through Provider TouCHPoint at texaschildrenshealthplan.org/providers.

ROLE OF LONG TERM SERVICES AND SUPPORTS (LTSS) PROVIDERS

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

- Verifying member eligibility
- Obtaining authorizations for services prior to provision of those services
- Initiating services within seven days of authorization for non-Home and Community-based Services (HCBS) STAR Kids Waiver members unless the referring provider or member requests otherwise
- Coordinating Medicaid/Medicare benefits
- MDCP services documentation and reporting requirements
- Notifying Texas Children's Health Plan of changes in a member's physical condition or eligibility
- Partnering with Texas Children's Health Plan Service Coordinator in managing a member's health care
- Managing continuity of care
- Employment Assistance providers must develop and update quarterly a plan for delivering Employment Assistance Services
- Supported Employment providers must develop and update quarterly a plan for delivering Supported Employment Services
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101 All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Texas Children's Health Plan if a member experiences any of the following:
 - A significant change in the member's physical

or mental condition or environment

- Hospitalization
- An emergency room visit
- Two or more missed appointments

ROLE OF TEXAS CHILDREN'S HEALTH PLAN SERVICE COORDINATOR

A Service Coordinator is the central contact between Texas Children's Health Plan and a Member's Providers, and family members to develop a complete service plan and provide the following services:

- Nursing Facility Care
- Acute care
- Behavioral Health
- Environmental care
- Functional care
- Home and community-based care

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

ROLE OF A TEXAS CHILDREN'S HEALTH PLAN TRANSITION SPECIALIST

A transition specialist assists the member to transition from pediatric to adult healthcare. They prepare the members and families for this transition and ensure continuity of care and supports the member's goals to take responsibility for their health care. Transition planning includes the following activities:

- Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service, or they transition to STAR+PLUS or community providers for Members of CHIP and STAR as applicable
- For STAR Kids Members, prior to the age of 10,

SECTION I. INTRODUCTION

the Transition Specialist informs the Member and the Member's Legal Authorized Representation (LAR) regarding LTSS programs offered through the Health and Human Services Commission (HHSC) and, if applicable, provides assistance in completing the information needed to apply. HHSC LTSS programs include Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS)

- Beginning at age 15, Texas Children's Health Plan begins quarterly updates to the ISP/Care Plan with transition goals
- Coordination with Department of Assistive and Rehabilitative Services (DARS) to help identify future employment and employment training opportunities is initiated by the Transition Specialist for STAR Kids Members as applicable
- If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) is made to ensure consistency of goals
- Health and wellness education occurs to assist the Member with Self-Management of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood
- Assistance in applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday is provided
- Assistance in identifying adult healthcare providers is done in collaboration with the Member's PCP

ROLE OF PHARMACY

Texas Children's Health Plan will subcontract with Navitus Health Solutions (Navitus) to provide Pharmacy Benefit Management (PBM) services. Texas Children's Health Plan and Navitus will work together to manage the pharmacy benefit for Texas Children's Health Plan STAR Kids Members. Some examples of current practices that will also apply to all STAR Kids Members include:

- Allowing all pharmacies to fill prescriptions for covered drugs ordered by any licensed Provider, regardless of network participation
- Adjudicating preferred drugs as payable without prior authorization, unless they are subject to clinical edits (as identified by HHSC)

- For drug products purchased by a pharmacy through the Health Resources Services Administration (HRSA) 340b discount program, Navitus will only impose clinical edit prior authorization requirements. These drugs are exempt from all Preferred Drug List (PDL) prior authorization requirements and will be processed accordingly
- Excluding coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program, drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI), and drugs for the purpose of enhancing sexual performance

Maintaining a comprehensive network of retail pharmacies is crucial to Texas Children's Health Plan administration of the STAR Kids pharmacy benefit. To that end, Texas Children's Health Plan supports pharmacies in many ways, including providing pharmacy education, supporting e-prescribing, helping network pharmacies become Medicaid-enrolled Durable Medical Equipment (DME) Providers and negotiating reasonable pharmacy Provider reimbursement rates.

ROLE OF MAIN DENTAL HOME

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.

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.

NETWORK LIMITATIONS

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

SECTION I. INTRODUCTION

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).

Please be advised of the following practitioner rights under NCQA for practitioners who are undergoing the credentialing process:

- Practitioners have the right to review information submitted by outside sources (malpractice insurance carriers, state licensing boards, etc.) to support their credentialing application. Texas Children's Health Plan is not required to make available references, recommendations or peer review protected information.
- Practitioners have the right to correct erroneous information identified in their credentialing application. Corrections must be submitted in writing to the Texas Children's Health Plan Credentialing Department at TCHPCredentialing@texaschildrens.org within (10) days.
- Practitioners have the right to receive the status of their credentialing or re-credentialing application, upon request, by emailing the Credentialing Department at TCHPCredentialing@texaschildrens.org. If a practitioner inquires about the status of their credentialing application, the credentialing staff will review the practitioner's CAQH application and the status of the credentialing file, including pending and/or completed primary source verifications with Verisys. Once the staff determines the completeness and anticipation of credentialing committee review timeframe, the provider will be notified of their credentialing status via email. Credentialing status inquiries received via the provider hotline, will be forwarded by member services to the credentialing department.

Additionally, providers performing laboratory testing must complete the Clinical Laboratory Improvement Amendments (CLIA) credentialing process and re-credentialing process to participate in Texas Children's Health Plan's network. The CLIA re-credentialing

process will occur at least every twenty-four (24) months or as directed by HHSC. Providers that change laboratory test complexity must attain recertification and complete re-credentialing at least six (6) months prior to performing the services.

The following information and documentation is required to complete the CLIA credentialing and re-credentialing process:

- PDF copy of current CLIA Certificate for all Certificate of Compliance (COC) and Certificate of Accreditation (COA) accreditations
- NPI or an Administrative Provider Identification Number (APIN)
- Copy of current, valid license to practice in area of specialty in the state of Texas
- Proof of Board Certification in area of specialty
- Copy of current professional malpractice liability coverage with limits that meet TCHP criteria (please include dates and amount of current malpractice insurance)
- Lack of any pending or open investigations from any state or governmental professional disciplinary body. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent. Must not be currently excluded, expelled, or suspended from any state or federally funded program. Additionally, must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
- Copy of the Accreditation Certificate from a recognized accrediting body, Centers for Medicare and Medicaid Services (CMS) State Survey, or any applicable State Survey (for facility applicants)

Texas Children's Health Plan has adopted CAQH (Council for Affordable Quality Healthcare, Inc.) for initial credentialing and re-credentialing for our provider network. All required information and documentation must be submitted to CAQH. To learn more about CAQH, call 1-888-599-1771 or visit their website at caqh.org/. If you have any questions or concerns regarding the required information or documents, please contact the CAQH Help Desk at 1-888-599-1771 or visit <https://upd.caqh.org/oas>. Providers not registered with CAQH should refer to the most current Texas Standardized Credentialing

SECTION I. INTRODUCTION

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 TCHPCredentialing@texaschildrens.org. You may request Texas Children's Health Plan's complete Credentialing and Re-credentialing Policy by emailing TCHPCredentialing@texaschildrens.org.

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

SECTION II. DEFINITIONS

1915(i) Home and Community Based Services—Adult Mental Health (HCBS-AMH)

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each Member's needs, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

Community Living Assistance and Support Services (CLASS) Waiver Program

The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program

The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Dual-Eligible

Medicaid recipients who are also eligible for Medicare.

Home and Community-based Services (HCS) Waiver Program

The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Long Term Services and Supports (LTSS)

LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

Medical Dependent Children Program (MDCP) Waiver Program

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

Texas Home Living (TxHmL) Waiver Program

The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

Youth Empowerment Services (YES) Waiver Program

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

SECTION III. COVERED SERVICES

Star Kids benefits are governed by Texas Children's Health Plan's contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, pharmacy and long term services and supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP. For updated list of covered services refer to Texas Medicaid Provider Procedures Manual (TMPPM) STAR Kids Manual.

TEXAS HEALTH STEPS SERVICES

These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM).

Documentation of completed Texas Health Steps components and elements

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

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

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

- I. Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
 - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.

- 2. Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening.
 - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
- 3. Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
 - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
 - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
 - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
 - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit <https://www.dshs.texas.gov/immunize/tvfc/>.
- 4. Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
 - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the

SECTION III. COVERED SERVICES

screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

- Anemia screening at 12 months.
- Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
- HIV screening at 16-18 years
- Risk-based screenings include:
 - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.
- 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>

5. Health education (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

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

- Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

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

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

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for listing of limitations and exclusions:

www.tmhp.com/pages/medicaid/medicaid_publications_provider_manual.aspx

Description of Long Term Services and Support Services (LTSS)

- **Adaptive Aids-** These are items or services necessary to assist the member to maintain function or treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function. Adaptive Aids enable individuals with functional impairments to perform activities of daily living or to control the environment in which they live. Texas Children's Health Plan will be responsible for STAR KIDS MDCCP Members only.
- **Community First Choice Services (CFC)-** is a program that enables Texas Medicaid recipients with disabilities to receive the most cost effective approach to basic attendant and habilitation service delivery.
- **Day Activity and Health Services (DAHS)-** Facilities that provide services to individuals who live in the community as an alternative to living in a nursing home or other institution. Services address physical, mental medical and social needs. This service is for Members 18 of age and older.
- **Employment Assistance (EA)-** Provides an individual to locate competitive employment in the community. EA is provided by a direct service agency or by a provider hired by the Consumer Directed Services (CDS) employer. Texas Children's Health Plan will be responsible for STAR KIDS MDCCP Members only.
- **Financial Management Services (FMS)-** Services delivered by the Financial Management Services

SECTION III. COVERED SERVICES

Agency to an employer such as orientation, training, support, assistance with and approval of budgets, and processing payroll and payables on behalf of the employee. Provides financial management services to people who receive certain services from the Health and Human Services Commission (HHSC) who have chosen to take responsibility for coordinating their own services through the Consumer Directed Services (CDS). This will include Support Consultation for Consumer-Directed Service Option only.

- **Flexible Family Support Services-** are individualized and disability-related services that support an individual to participate in child care, independent living and post-secondary education. Flexible Family Support Services include personal care supports for basic activities of daily living (ADL) and instrumental ADL, skilled task and delegated skilled task supports. Texas Children's Health Plan will be responsible for STAR Kids MDCP Members only.
- **Minor home modifications-** Services that assess the need to arrange for and provide modifications and/or improvements to the individual's quarters to allow for community living and ensure safety, security and accessibility. Minor home modifications (MHM) do not include major home renovations, remodeling or construction of additional rooms. By rule, the Community Living Assistance and Support Services (CLASS) program assures that minor home modifications are:
 - Cost effective
 - Associated with the related condition
 - Necessary to avoid institutionalization
 - Provide safe access to the home and community
 - Improve self-reliance and independence

Texas Children's Health Plan will be responsible for STAR KIDS MDCP Members only.

- **Personal Care Services (PCS)-** Support services provided to a person eligible for THSteps-CCP services who requires assistance with ADLs or IADLs due to physical, cognitive, or behavioral limitations related to his or her disability or chronic health conditions.
- **Private Duty Nursing (PDN)-** Services that are provided in a individuals home- and are beyond what a certified home health agency can provide.
- **Respite Care-** Respite means having someone else

look after your loved one while caregiver takes a break. Respite takes place either in the home or of a family or friend or at a location in the community. Texas Children's Health Plan will be responsible for STAR Kids MDCP Members only.

- **Supported Employment-** A program offered to individuals who are interested in obtaining and maintaining employment in the community. Supported employment is based on the principal that everyone can and has the right to work. Jobs are sought based on the individual's interest, preferences and abilities. The program provides a variety of services such as job coaching, transportation and on-going support. Texas Children's Health Plan will be responsible for STAR Kids MDCP Members only.
- **Transition Assistance Services (TAS)-** Helps people who reside in a nursing facility and who are Medicaid –eligible to set up a household in the community if the person will be enrolling in one of the following Medicaid waiver programs upon discharge from the nursing facility. Texas Children's Health Plan will be responsible for MDCP Members only.
- **Prescribed Pediatric Extended Care Centers and Private Duty Nursing-** A client has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC), or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A client may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the client's medical condition or the authorized hours are not commensurate with the client's medical needs. In accordance with 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.
- **Attention Deficit Hyperactivity Disorder (ADHD)-** Texas Children's Health Plan will contact all newly prescribed ADHD members and mail ADHD information packet post initial fill. Contact ADHD members after 4 consecutive refills and remind them they need to follow up with their prescribing MD again before the end of the 180th day post first fill. Reimbursement for these services will be determined according to the Provider Agreement.

SECTION III. COVERED SERVICES

SERVICE COORDINATION SERVICES

Role of a Texas Children's Health Plan Service Coordinator

A Service Coordinator is the central contact between Texas Children's Health Plan and a Member's Providers, and family members to develop a complete service plan and provide the following services:

- Nursing Facility Care
- Acute care
- Behavioral Health
- Environmental care
- Functional care
- Home and community-based care

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. The Service Coordinator must work with the Member's PCP to coordinate all Covered Services, non-capitated services, and non-covered services available through other sources. This requirement applies regardless of whether the PCP is in the Health Plan's Network. In order to integrate the Member's care while remaining informed of the Member's needs and condition, the Service Coordinator must actively involve the Member's primary and specialty care Providers, including Behavioral Health Service Providers, and Providers of non-capitated services and non-covered services.

Providers can access the Service Coordination department for the STAR Kids member at Texas Children's Health Plan by calling **832-828-1004** or **1-877-213-5508**. The Service Coordinator will be notified to contact the provider.

STAR Kids Screening and Assessment Instrument

The STAR Kids Screening and Assessment Instrument (SAI) is designed as a standard screening and assessment process. It assists in: determining eligibility for Medicaid-funded community long term services and supports (LTSS) for the MDCP population, identifying individuals' support needs, and informing their service and support planning (e.g., plan of care).

The STAR Kids Screening and Assessment Instrument (SAI) is an electronic assessment and screening tool that is used to help identify the potential need for Personal Care Services and nursing services, behavioral health, physical therapy, occupational therapy and speech therapy services.

STAR Kids Screening and Assessment Process

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

The Texas Children's Health Plan Service Coordination Program has three tiers of Service Coordination and assign Members to the appropriate tier based on their level of need. Texas Children's Health Plan may use a Health Home employee as the named Service Coordinator.

Texas Children's Health Plan provides the following for all STAR Kids Members:

- A description of Service Coordination;
- A phone number to contact if the Member needs Service Coordination or is experiencing problems with Service Coordination;
- The name of their Service Coordinator, if applicable;
- The phone number and e-mail address of their named Service Coordinator or information on how to reach a Service Coordinator if the Member does not have a named Service Coordinator;
- The minimum number of contacts the Member will receive every year; and
- The types of contacts the Member will receive and instructions on how to request additional Service Coordination assistance at any time
- How to access a Member Advocate if the Member has complaints about a Service Coordinator

If the named Service Coordinator changes, Texas Children's Health Plan notifies Members within 5 Business Days of the name and phone number of their new Service Coordinator. Within the same time period, Texas Children's Health Plan also posts the new Service Coordinator's information on the portal or website Members use to obtain plan information. If the Member is in a Nursing Facility when the change occurs, the Nursing Facility is notified of the new Service Coordinator's contact information within 5 days.

The structure of the Texas Children's Health Plan Service Coordination Levels is based on findings from the Member, the Member's LAR, and relevant service Providers in addition to assessment information.

SECTION III. COVERED SERVICES

Level 1 Members

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

Level 2 Members

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

Level 3 Members

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

Individual Service Plan

A plan that is created by Service Coordinator, Member and LAR that supports the member in obtaining needed services and referrals in a manner respecting the individuality and preferences of the Member.

Discharge Planning

In support of successful discharge planning to transition a Member back to the community, the Texas Children's Health Plan Service Coordinator works with the Member's PCP/admitting physician, the hospital/inpatient psychiatric facility discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. The discharge planning process is initiated at notice of inpatient admission. Texas Children's Health Plan's

Utilization Management (UM) Specialists identify the needs of Member's related to acute inpatient episodes of care, collaborating with the facility case managers to proactively identify setting, service, and equipment requirements beginning on the day of admission. The UM Specialists notifies the Service Coordinators of admission to initiate the process.

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

Continuity of Care Transition Plan

Transition Specialists are wholly dedicated to transition support and trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process.

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

ADULT TRANSITION PLANNING

Texas Children's Health Plan will help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. The Health Plan will provide transition planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division.

Transition planning will include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the Health Plan must inform the Member and the Member's LAR regarding LTSS programs offered through the Health and

SECTION III. COVERED SERVICES

Human Services Commission (HHSC). HHSC LTSS programs include MDCP, YES, CLASS, DBMD, TxHmL, and HCS.

3. Beginning at age 15, the Health Plan must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the Member with Self-Management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult healthcare providers.

MDCP/DBMD ESCALATION HELP LINE

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about External Medical Reviews, State Fair Hearings and continuing services during the appeal process.

When should Members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive

benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

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/healthcare-programs/healthy-texas-women/htw-benefits>

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>

SECTION III. COVERED SERVICES

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>

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>

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>

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
- 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

SECTION III. COVERED SERVICES

- 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.

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>

COORDINATION WITH NON-MEDICAID MANAGED CARE COVERED SERVICES (NON-CAPITATED SERVICES)

Medicaid Non-Capitated Services

The following Texas programs, services, or benefits have been excluded from Texas Children's Health Plan Covered Services. Members may be eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis or through a Dental Health Plan (for most dental services). For more information the Provider can go to Texas Medicaid Provider Procedures Manual (TMPPM):

- Texas Health Steps dental (including orthodontia)

- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) targeted case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by Department of State Health Services (DSHS-approved Providers (directly observed therapy and contact investigation)
- Health and Human Services Commission (HHSC) hospice services
- HHSC or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, TxHmL and YES

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>.

NON-EMERGENCY 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.

SECTION III. COVERED SERVICES

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 NEMT services or

Member Transportation, please refer him or her to Texas Children's Health Plan at **1-888-401-0170** (toll free) or **1-346-232-4130** (local) for more information.

BEHAVIORAL HEALTH

Definition of Behavioral Health

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

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

Medically necessary behavioral health services are:

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

The mental health priority populations are those individuals served by Texas Mental Health Mental Retardation (TXMHMR).

This group is defined as children and adolescents, under the age of 18, who exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.

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

SECTION III. COVERED SERVICES

Behavioral Health Covered Services

Texas Children's Health Plan has a toll-free number for members to use on a 24-hour, 7-day-a-week basis, answered by health professionals who will assist in identifying an appropriate provider for the patient. STAR Kids members may call **1-844-818-0125**. (The primary care provider is responsible for maintaining treatment records and obtaining a written medical record release from the member or a parent/legal guardian of the member before records can be released.)

Available behavioral health services include:

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

Texas Children's Health Plan is responsible for authorized inpatient Hospital services, this includes services provided in Freestanding Psychiatric Facilities.

Primary Care Provider Requirements for Behavioral Health

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

Texas Children's Health Plan has a comprehensive network of behavioral health service providers for the treatment of mental health and drug and alcohol abuse issues.

Member Access to Behavioral Health Services

Texas Children's Health Plan has a toll-free number for members to use on a 24-hour, 7-day-a-week basis, answered by health professionals who will assist in

identifying an appropriate provider for the patient. STAR Kids members may call **1-844-818-0125**. The primary care provider is responsible for maintaining treatment records and obtaining a written medical record release from the member or a parent/legal guardian of the member before records can be released.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a common behavioral disorder that begins in early childhood and can continue through adolescence and into adulthood. ADHD makes it difficult for a child to focus and pay attention. Some children may be hyperactive and have trouble being patient or sitting still. For those experiencing ADHD, levels of inattention, hyperactivity, and impulsive behaviors are greater than for other children in their age group. ADHD can make it hard for a child to do well in school, at home, or in the community. Adults may have difficulty staying on task at work or following instruction. There are effective ways of treating ADHD. Whether a child or adult, often individuals with ADHD respond to cognitive behavioral therapy. Furthermore, provider education and coaching of parents/guardians with an ADHD child or adolescent has shown to greatly improve symptoms by teaching ways to improve social structure and support system necessary for success. In some cases, along with counseling and education, medication may be needed to help a person with ADHD. A qualified in-network physician can help make that determination as well as recommend which medication would be best to help decrease the presenting symptoms. Once a medication is started, regular visits to the prescribing physician are necessary to monitor effectiveness and possible side effects. Lastly, a prescribed medication should never be stopped without first consulting the physician. The interventions discussed above are services covered by Texas Children's Health Plan and are readily available to those individuals who are experiencing ADHD. If ADHD is being considered, the best place to start is with the Primary Care Physician.

Health Home

A Health Home provides services to STAR Kids in Health Home Services must include:

- Pediatric and obstetrical care
- Dental care
- Optometry services
- Behavioral health and speech and therapy services
- Patient self-management education

SECTION III. COVERED SERVICES

- Provider education
- Patient and family support (including authorized representatives)

Self Referral

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

A Texas Children's Health Plan primary care provider can call Texas Children's Health Plan at **832-828-1004** or toll free at **877-213-5508** to refer patients for behavioral health services or a Texas Children's Health Plan member may self-refer, without referral from primary care provider, to any in-network behavioral health care provider. Texas Children's Health Plan provides information to members regarding how and where to obtain behavioral health services.

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

Medical Records documentation and referral information are required to document when using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Texas Children's Health Plan must provide inpatient or outpatient psychiatric services to Members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Texas Health and Safety Code Chapters 573 and 574, relating to Court-Ordered Commitments to inpatient mental health facilities. Texas Children's Health Plan is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. These placements are Non-capitated Services.

Texas Children's Health Plan cannot deny, reduce or controvert the Medical Necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members under the age of 21.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

A Member who has been ordered to receive treatment under Texas Health and Safety Code Chapter 573 or 574 can only appeal the commitment through the court system.

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

For STAR Kids members, Texas Children's Health Plan Service Coordinator can assist in:

- Referring or arranging for referral of Members to LMHAs for assessment and services, as appropriate
- Referring Members to the LMHA for IMD level of care determination for CFC
- Collaborating with the LMHA to arrange for community based services needed to support the Member in lieu of or following inpatient hospitalization, Texas Children's Health Plan providers must use the current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classification and report axes for the assessment of behavioral health/mental health diagnoses. This information as well as assessment/outcome information is to be documented in the member's medical record. Behavioral health/mental health assessment tools include the:
 - PSC-Y Pediatric Symptom Checklist for Youth (Assessment of depression, anxiety, ADHD, conduct disorder, oppositional defiant disorder and suicidality. For ages 11–18. Available at Teenscreen website below.
 - PHQ-9 Patient Health Questionnaire (Depression and Suicidality) available at Teenscreen website below.
 - CRAFFT for adolescents and adults (Substance Abuse Questionnaire): Available at Teenscreen

SECTION III. COVERED SERVICES

website below.

- For the PSC-Y, PHQ-9 and CRAFFT assessments in English and in Spanish please visit tspn.org.
- Brief Psychiatric Rating Scale (BPRS)—(Ages 17 and older) can be downloaded from <https://www.smchealth.org/sites/main/files/file-attachments/bprsform.pdf?1497977629>
- Global Assessment Functioning Scale (GAF)—Scores for patients of all ages (scores are to be documented upon admission and upon discharge or every 3 months during treatment).
- Behavioral health providers are required to refer members with physical health problems to their primary care provider for treatment. Members must also obtain lab and ancillary tests for behavioral health conditions at participating provider locations.

Behavioral Health Focus Studies and Utilization Management Reporting

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

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

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

Behavioral Health Value-Added Services

Additional Transportation- If transportation is a barrier to attending medical visits, Texas Children's Health Plan will, upon verification of medical appointments, arrange for transportation through taxi services, wheelchair VAC, or other non-medical transportation services. If member has access to private vehicle transportation, Texas Children's Health Plan may offer a prepaid gasoline card to reimburse for mileage. The dollar amount for gasoline reimbursement will be calculated on mileage for the trip but not to exceed \$20 dollars per round trip. Some exceptions to increased amounts about \$20 may be made for members who live in rural areas with high distances to travel.

Caregiver Respite Care Services- Texas Children's Health Plan understands that being a family caregiver for a special needs child is a heavy responsibility and is taxing both physically and emotionally. There are times when the family member who carries that burden simply needs a short break to recover. While respite care is a limited benefit for Members with MDCP and waiver programs, the children covered under SSI do not have such a benefit. Therefore, in support of those families, Texas Children's Health Plan proposes to offer eight hours of in-home respite services as an extension of their home and community-based services.

Smoking Cessation Benefits- Texas Children's Health Plan is offering smoking cessation benefits as a value-added service for STAR Kids Members because we understand the importance of a smoke-free environment for children. Up to \$50 above the basic benefit – for nicotine replacement products including over the counter and prescription items.

Health coaching, education and referral to approved programs offered free of charge to tobacco dependent parents of all members that agree to coaching.

Parent Training- Texas Children's Health Plan understands that being a caregiver for a special needs child is a heavy responsibility, one that is taxing both physically and emotionally. Parent training programs can be critical in helping a caregiver understand the needs of their child as well as provide a valuable support system. Texas Children's Health Plan is offering accredited parent training seminars on a variety of topics from which parents of STAR Kids Members may choose. Topics include caring for children with certain diagnoses, such as ADHD or Autism; navigating special education opportunities and services; and parent training on advocating for children with intellectual or developmental disabilities. Parents may attend any accredited seminar.

Post Hospitalization Follow-Up Visit Incentive- STAR Kids members may receive a gift card for substantiating a follow up visit post hospitalization. The follow up visit must be rendered within 7-14 days of discharge from the hospital. A receipt of the follow up visit card must be returned by the member in order to receive the gift card. The cards are sent to the member by the Health Plan. On the card, the doctor states the follow up visit date, hospital discharge date, with member's name, date of birth and ID number, and physician signature.

SECTION III. COVERED SERVICES

The member must be an active member at the time of verification.

A post hospitalization visit card is sent after hospital discharge to Texas Children's Health Plan STAR Kids members: There is a tear off portion for the member to have their doctor sign at the follow up visit. Then the member sends that card back in to Texas Children's Health Plan. Once received by Texas Children's Health Plan the gift card is mailed.

Behavioral Health Emergencies

Emergency services may be delivered at network or non-network sites. The Health Plan contracts with mobile outreach services and specialized Behavioral Health facilities as well as emergency rooms to deliver emergency behavioral services. Texas Children's Health Plan network services are available 24 hours a day without restrictions or preauthorization requirements. We accept the emergency Provider's determination of stability related to transfer or discharge providing approval to post-stabilization care services as necessary in compliance with Federal and State regulation. Texas Children's Health Plan assists in coordination of inpatient admission if needed as well as follows the Member to support implementation of the discharge plan of care and to ensure successful transition to community-based services.

In addition to Member and Family education through the Member Handbook, Member newsletters, and Health Plan website, Texas Children's Health Plan Service Coordinators, with input from the care team, also provide direct and individualized training and support to the Member and their support network specific to responding to emergencies. The primary tool for this support is the person-centered crisis plan developed with the Member and their support network. Through the crisis planning process, potential triggers to emergency events are identified and Members and support persons are engaged to determine interventions that are realistic and have shown to be successful for the Member in the past. Additional resources for preventing and managing crises are also introduced and discussed for inclusion in the plan. Ownership of the plan by both the Member and their support network fosters responsibility in management of their outcomes and provides education on strategies for seeking support early when a Member's condition first begins to decompensate. The crisis plan is communicated to everyone on

the treatment team and provided to the Member's support network for easy access and availability for periodic review.

Substance Use Disorder and Specialized Service Coordination

Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM):

- Texas Children's Health Plan will provide specialized Service Coordination to Members with a substance use disorder. Texas Children's Health Plan will work with Providers, facilities, and Members to coordinate care for Members with a substance use disorder and to ensure Members have access to the full continuum of Covered Services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as medically necessary and appropriate. Texas Children's Health Plan will also coordinate services with DSHS, DFPS, and their designees for Members requiring Non-Capitated Services. Non-Capitated Services include, without limitation, services that are not available for coverage under this STAR Kids Program, State Plan, or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. Texas Children's Health Plan will work with DSHS, DFPS, and providers to ensure payment for Covered Services is available to Out-of-Network Providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

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

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

SECTION III. COVERED SERVICES

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

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

Severe and Persistent Mental Illness (SPMI)

Severe and Persistent Mental Illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
- Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services

Severe Emotional Disturbance (SED)

SED's are a group of psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling. Some serious emotional disorders are classified as mental illnesses. Children and adolescents generally have from two to four diagnoses.

Member Access to Benefits of MHR Services and TCM

For Members with an Intellectual or Developmental condition the Member must be eligible for Medicaid and meet an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) to qualify for Community First Choice services. The Local IDD Authority (LIDDA) conducts the eligibility assessment to determine eligibility and sends that assessment to HHSC's Administrative

Services Contractor for a determination. The LIDDA completes the Determination of Intellectual Disability (DID) and Intellectual Disability Related Condition (ID/RC) assessments.

Providers of MHR services and TCM services must use and be trained and certified to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs Strength Assessment (ANSA) for members 19 and 20.

Providers must use the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

Attestation from Provider entity to the Health Plan that organization has the ability to provide, either directly or through subcontract, the Members with the full array of MHR and TCM services as outlined in the RRUMG.

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM Services.

Provider Requirements

Providers of MHR services and TCM services must use and be trained and certified to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs Strength Assessment (ANSA) for members 19 and 20.

Providers must use the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

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

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM Services.

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

SECTION III. COVERED SERVICES

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. To facilitate this coordination of care, providers must utilize the Coordination of Care Referral Form available as attachment H in the appendix of this manual to communicate with one another regarding patient referrals and overall health care updates.

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.

QUALITY MANAGEMENT

Clinical Practice Guidelines

Texas Children's Health Plan will adopt not less than two evidence-based clinical practice guidelines. The clinical practice guidelines are updated at least once every two years. These practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the Health Plan's Members, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate. The Health Plan will develop practice guidelines based on the health needs and opportunities for improvement identified as part of the Quality Assurance Provider Incentive (QAPI) Program.

The Health Plan may coordinate the development of clinical practice guidelines with other STAR Kids Health Plans so that Service Area Providers do not receive conflicting practice guidelines from different Health Plans.

Texas Children's Health Plan will make available the practice guidelines to all affected Providers and, upon request, to Members and potential Members. The guidelines can be found on the website at <http://www.tchp.us/for-providers/provider-resources/practice-guidelines> and on our provider portal. 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.

The Health Plan will take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until 90 percent or more of the Providers are consistently in compliance, based on the Health

Plans measurement findings. The Health Plan will employ substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The Health Plans decisions regarding Utilization Management, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the Health Plan clinical practice guidelines.

Behavioral Health Focus Studies and Utilization Management Reporting

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

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

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

SECTION IV. PROVIDER RESPONSIBILITIES

PRIMARY CARE PROVIDER RESPONSIBILITIES (MEDICAL HOME RESPONSIBILITIES)

Primary care provider (medical home) responsibilities excludes STAR Kids dual eligible members.

Texas Children's Health Plan Network may include Providers from any of the following practice:

- General Practice
- Family Practice
- Internal Medicine
- Pediatrics
- Obstetric/Gynecology (OB/GYN)
- Advance Practice Registered Nurses (APRNs)
- Physician Assistants (PAs)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs), and similar community clinics; and
- Specialists physicians who are willing to provide a Health Home to selected Members with special needs and conditions

Texas Children's Health plan require PCPs to coordinate with members, Caregivers other Providers, STAR Kids Service Coordinators, and state and non-state entities to assure that the Member's medical and behavioral health needs are met. Other PCP requirements include screening, identification, and referral to Medically Necessary or Functionally Necessary Covered Services and assessment and coordination of non-clinical services that impact the Member's health. Texas Children's Health Plan must ensure that all STAR Kids PCPs provide patient- and family-centered care that serves the goals of improving Member care, outcomes and satisfaction.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

- The Provider assumes all Texas Children's Health Plan responsibilities for such Members in a specific age range from birth through age 20
- The Provider has a history of practicing as a PCP for the specified age range, as evidenced by the Provider's primary care practice including an established patient population within the specified age range, and

- The Provider has admitting privileges to a local Hospital that includes admissions to pediatric units

Performing Obligations within the United States

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

Differences between PCP and Health Home

A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. The PCP may be a specialist physician who agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the Contract and such PCP duties must be within the scope of the specialist's license. The Member or the Member's LAR may initiate the request through Texas Children's Health Plan for a specialist to serve as a PCP for the Member. Texas Children's Health Plan must process such requests in accordance with 28 Tex. Admin. Code § 11.900. Specialists may limit the number of Members for whom they will serve as a PCP.

Texas Children's Health Plan must provide access to a Health Home to any Member the Plan determines would most benefit from a Health Home or for any Member who requests a Health Home. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

SECTION IV. PROVIDER RESPONSIBILITIES

Health Home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition. Health Home services must include:

- Patient self-management education
- Provider education
- Patient-centered and family-centered care
- Evidence-based models and minimum standards of care; and
- Patient and family support (including authorized representatives)

Health Home Services may also include:

- A mechanism to incentivize providers for provision of timely and quality care;
- Implementation of interventions that address the continuum of care;

- Mechanisms to modify or change interventions that are not proven effective;
- Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;
- Comprehensive care coordination and health promotion;
- Palliative care options in the event of a life-limiting diagnosis;
- Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
- Data management focused on improving outcome-based quality
- Referral to community and social support services, if relevant; and
- Use of health information technology to link services, as feasible and appropriate

Availability and Accessibility

Texas Children’s Health Plan PCPs are encouraged to offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Service	Texas Children’s Health Plan Response Standard
Emergency care	Upon member presentation at service delivery site, including non-network and out-of-area facilities
Urgent care, including urgent specialty care	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 days of request
Routine specialty care appointment	Provided within 21 days
Initial outpatient behavioral health visit	Provided within 14 days of request
Routine prenatal care	Provided within 14 days of request or immediately if an emergency exists.
Prenatal care for high-risk pregnancies or new members in third trimester	Appointment offered within 5 days, or immediately if an emergency exists.
Preventive health care services for children	Offered in accordance with Texas Health Steps Periodicity Schedule
Newborns	In no case later than 14 days of enrollment of Texas Health Steps Periodicity Schedule
Existing member overs 36 months annual checkup within 364 days of birthday	Provided within 90 days of request
Initial outpatient behavioral health visits upon discharge from an inpatient psychiatrist setting	Provided within 7 days of request
New member	Provided within 90 days of request
Community-based services for Non-MDCP STAR Kids waiver members	Initiated 7 days from the date the MCO authorizes services unless the referring provider or member states otherwise

SECTION IV. PROVIDER RESPONSIBILITIES

Acceptable After-hours Coverage

- The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
- The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable; and
- The 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 practitioner, who can return the call within 30 minutes.

Unacceptable After-hours Coverage

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

All Texas Children's Health Plan Primary Care Providers (PCP), will provide children birth through age 20 with preventive services in accordance with the Texas Health Steps periodicity schedule. For those adult members over age 18, PCPs are required to provide preventive services in accordance with the U.S. Preventive Services Task Force requirements.

This section does not apply to Dual Eligible Members.

Reporting Updates to Contact Information

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

Provider and Care Coordination.

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

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

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

Plan Termination

A primary care provider who elects to terminate Texas Children's Health Plan participation must notify Texas Children's Health Plan in writing or his/her respective IPA, if applicable, who in turn notifies Texas Children's Health Plan Provider Relations by fax or certified letter. Upon receipt, all terminations are subject to the terms and conditions of the provider's contract with Texas Children's Health Plan or the IPA. Texas Children's Health Plan will notify the member in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Texas Children's Health Plan to efficiently transfer patients to another primary care provider. Physicians are requested to continue care in progress until all members can be successfully transferred to a new primary care provider.

SECTION IV. PROVIDER RESPONSIBILITIES

Member Education about Member's Right to Designate an OB/GYN as their Primary Care

Texas Children's Health Plan members are informed that they have the right to select an OB/GYN without a referral from their primary care provider. Texas Children's Health Plan members may access the health services of an OB/GYN for their annual well woman exam, prenatal care, female medical conditions, and specialist referrals within the network.

Texas Children's Health Plan members have the right to designate their OB/Gyn as their Primary Care if the OB/Gyn accepts that responsibility.

STAR Kids Dual Eligible Members are excluded.

Specialist Functioning as Primary Care Provider

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

The application must:

- Include information specified by Texas Children's Health Plan and certification of the medical need.
- Be signed by the member and the non-primary care physician specialist interested in serving as the member's primary care physician.

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

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

Upon receipt of the completed form:

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

STAR Kids Dual Eligible Members are excluded.

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

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

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

Texas Children's Health Plan allows a member to select and have access to any pharmacy in the Texas Children's Health Plan network. Texas Children's Health Plan has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the STAR Kids program. For questions related to pharmacy, members should contact Texas Children's Health Plan Member Services at **1-866-959-2555**. For additional information please see the Role of Pharmacy in the Introduction section of this manual.

Member Information about Advance Directives

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

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

SECTION IV. PROVIDER RESPONSIBILITIES

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

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

Referral to Specialists and Health-related Services

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

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

STAR Kids Dual Eligible Members are excluded.

How to Help Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member's Main Dental Home

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

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

Primary Care Provider Requirements for Behavioral Health

Primary care providers must screen, evaluate, refer, and/or treat any behavioral health problems and disorders for Texas Children's Health Plan members. The primary care provider may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues. Texas Children's Health Plan has a comprehensive network of behavioral health service providers for the treatment of mental Health and drug and alcohol abuse issues.

STAR Kids Dual Eligible Members are excluded.

Referral to Network Facilities and Contractors

Authorizations for referrals to in-network specialists are not required. It is recommended that a primary care provider check with Texas Children's Health Plan Member Services to confirm specialist network status. Texas Children's Health Plan does not need a copy of the referral form.

The primary care provider is expected to refer Texas Children's Health Plan members to Texas Children's Health Plan providers, as needed, for behavioral health services. If a primary care provider is unsure that their patient requires behavioral health services, the primary care provider is encouraged to refer the patient to a behavioral health specialist to make that assessment by calling **832-828-1004** or toll free at **1-877-213-5508**. Texas Children's Health Plan members may self-refer to behavioral health providers for treatment. The behavioral health provider must attempt to obtain a release of information from the Texas Children's Health Plan member to allow the behavioral health provider and primary care provider to share this information. To authorize services, please call **832-828-1004** or toll free at **1-877-213-5508** or fax to **832-825-8760**.

SECTION IV. PROVIDER RESPONSIBILITIES

Members' Right to a Second Opinion

Texas Children's Health Plan members may access a second opinion regarding any health care service. A member must be allowed access to a second opinion from a network provider or out-of-network provider, if a network provider is not available, at no additional cost to the member.

Specialty Care Provider Responsibilities

Specialists are responsible for furnishing medically necessary services to Texas Children's Health Plan members who have been referred by their primary care provider for specified consultation, diagnosis, and/or treatment. The specialist must communicate with the primary care provider regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded

to the primary care provider. The specialist should also respond to requests from the Texas Children's Health Plan Utilization Management Program for pertinent clinical information that assists in providing a timely authorization for treatment. To obtain prior authorization for required services, please call **832-828-1004** or toll free at **1-877-213-5508** or fax to **832-825-8760**.

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

Availability and Accessibility

Texas Children's Health Plan members are assured timely access to services and availability of providers within the established standards, as noted below.

Service	Texas Children's Health Plan Response Standard
Emergency care	Upon member presentation at service delivery site, including non-network and out-of-area facilities
Urgent care, including urgent specialty care	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 days of request
Initial outpatient behavioral health visit	Provided within 14 days of request
Routine prenatal care	Provided within 14 days of request or immediately if an emergency exists.
Prenatal care for high-risk pregnancies or new members in third trimester	Appointment offered within 5 days, or immediately if an emergency exists.
Preventive health care services for children	Offered in accordance with Texas Health Steps Periodicity Schedule
Newborns	In no case later than 14 days of enrollment of Texas Health Steps Periodicity Schedule
Existing member over 36 months annual checkup within 364 days of birthday	Provided within 90 days of request
Initial outpatient behavioral health visits upon discharge from an inpatient psychiatrist setting	Provided within 7 days of request
New member	Provided within 90 days of request
Community-based services for Non-MDCP STAR Kids waiver members	Initiated 7 days from the date the MCO authorizes services unless the referring provider or member states otherwise

SECTION IV. PROVIDER RESPONSIBILITIES

Responsibility to Verify Member Eligibility and/or Authorizations for Service

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

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

TEXAS CHILDREN'S HEALTH PLAN CONTINUITY OF CARE IN THE FOLLOWING SITUATIONS:

Pregnant women information—Texas Children's Health Plan will take special care not to disrupt care in progress for newly enrolled members. Pregnant members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN provider (even if the provider is out of network) through the member's postpartum checkup. A member may change her OB/GYN if she requests.

Member moves out of service area—Texas Children's Health Plan requests that the member tell us in writing if they move, change their address or phone number, even if these changes are temporary. If a member moves out of the service area, they may no longer be eligible. Texas Children's Health Plan will provide or pay out-of-network providers who provide medically necessary covered services to members who move out of the service area through the end of the period for which capitation has been paid for the member.

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

Out-of-Network Providers

Texas Children's Health Plan ensure that the healthcare of newly enrolled Members is not disrupted, compromised, or interrupted. The Health Plan will take special care to provide continuity in the care of enrolled Members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted.

Upon notification from a Member or Provider of the existence of a Prior Authorization, Texas Children's Health Plan will ensure Members receiving services through a Prior Authorization from either another Health Plan or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: (1) 90 calendar days after the transition to Texas Children's Health Plan, (2) until the end of the current authorization period, or (3) until the Health Plan has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization.

Texas Children's Health Plan will have Member's existing Out-of-Network Provider for services provided to a pregnant Member past the 24th week of pregnancy extend through delivery of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery.

For Members active on the Operational Start Date

- a) Members receiving Community-Based Services on the STAR Kids Operational Start Date
- b) Member changes MCOs and has an existing prior authorization with their previous MCO
- c) Necessary, covered services are not available in-network
- d) Members receiving any other services on the STAR Kids Operational Start Date

For members who, at the time of enrollment in the MCO, have been diagnosed with and are receiving treatment for a terminal illness and remains in the MCO will continue to receive out of network benefits

SECTION IV. PROVIDER RESPONSIBILITIES

for a period not to exceed 12 months.

For members who are effective with another MCO or a Waiver program on Operational Start Date, Texas Children's Health Plan will utilize the previous authorization from either the MCO or FFS and continue for a period of up to 6 months or until Texas Children's Health Plan has appropriately evaluated and administered STAR Kids screening and assessment process and issued or denied a new authorization

Medical Records

Standards that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

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

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

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

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE) MEDICAID MANAGED CARE

Report suspected Abuse, Neglect, and Exploitation

Texas Children's Health Plan and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include Texas Children's Health Plan and provider

responsibilities related to identification and reporting of ANE. Additional state laws related to Texas Children's Health Plan and provider requirements continue to apply.

Report to the 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 HHSC;
- Adult day care centers; or
- Licensed adult foster care providers

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

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

- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
 - An adult with a disability receiving services through the Consumer Directed Services option

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

Report to Local Law Enforcement:

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

SECTION IV. PROVIDER RESPONSIBILITIES

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, 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, 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

Mandatory Challenge Survey

Texas Children's Health Plan is required to systematically and regularly verify that Covered Services are available and accessible to Members and be in compliance. For Covered Services furnished by PCPs, the Health Plan must be in compliance.

Texas Children's Health Plan is required to develop and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. Texas Children's Health Plan will design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing the Texas Children's Health Plan Provider portal functionalities. The challenge survey must include verification of the following elements:

- 1) Provider Name;
- 2) Address;
- 3) Phone Number;
- 4) Office Hours;
- 5) Days of Operation;
- 6) Practice Limitations;
- 7) Languages Spoken;
- 8) Provider Type / Provider Specialty;

- 9) Wait times for appointment; Length of time a patient must wait between scheduling an appointment and receiving treatment
- 10) Accepting new patients (PCPs only);
- 11) Texas Health Steps Provider (PCP only); and
- 12) Whether the provider offers telemedicine, telehealth, or telemonitoring

Texas Children's Health Plan will enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the Health Plan to be out of compliance.

LONG TERM SERVICES AND SUPPORTS

Long Term Services and Supports (LTSS) providers are responsible for, but not limited to, the following

- Verifying member eligibility
- Obtaining precertification for services prior to provision of those services
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in members' physical condition or eligibility
- Collaborating with Texas Children's Health Plan's service coordinator in managing members' health care
- Managing continuity of care for STAR Kids members

Community First Choice Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan
- The program provider must maintain current documentation which includes the member's service plan, Intellectual Disability Related Condition (ID/RC) (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- 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

SECTION IV. PROVIDER RESPONSIBILITIES

availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.

- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline:

1-800-647-7418

- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide

registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.

- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the Health Plan's 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.

Employment Assistance

Providers must develop and update quarterly a plan for delivering employment assistance services. Employment Assistance means assistance provided to a STAR Kids member to help the member locate paid employment in the community.

Employment assistance includes:

- Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements
- Contacting a prospective employer on behalf of a member and negotiating the member's employment

SECTION IV. PROVIDER RESPONSIBILITIES

Supported Employment

Providers must develop a plan and update it quarterly for delivering supported employment services. Supported Employment means assistance provided to a STAR Kids member in order to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed.

Supported Employment includes:

- Employment adaptations
- Supervision
- Training related to a member's diagnosis

Other services provided by job coaches include assisting with the application process, preparing for interviews, and working with the individual at the work site in order to learn the skills needed to succeed at his or her job. Job coaches are available to provide employers with suggestions on how to help integrate individuals into the work environment.

PHARMACY PROVIDER RESPONSIBILITIES

Texas Children's Health Plan has an arrangement with Navitus Health Solutions, a pharmacy benefit management company, to administer pharmacy benefits for Texas Children's Health Plan STAR Kids members. For questions related to formulary, preferred drug list, billing, prescription overrides, prior authorizations, quantity limit, or formulary exceptions, please call Navitus at **1-866-333-2757** or access the Navitus website at navitus.com

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

Drugs eligible for Texas Children's Health Plan reimbursement are listed in the current Texas Listing of National Drug Codes. Providers can find a list of preferred drugs at navitus.com through the provider portal or by calling **1-866-333-2757**.

COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

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

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

EMERGENT, URGENT, AND ROUTINE SERVICES

Emergent/Emergency Services

Emergency services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or and emergency behavioral health condition, including post-stabilization care services. Emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

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

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

SECTION IV. PROVIDER RESPONSIBILITIES

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

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

Urgent Care Services

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

Routine Care Services

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

SECTION IV. PROVIDER RESPONSIBILITIES

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

REQUIREMENTS FOR SCHEDULING APPOINTMENTS

Availability and Accessibility

Texas Children’s Health Plan members are assured timely access to services and availability of providers within the established standards, as noted below.

Service	Texas Children’s Health Plan Response Standard
Emergency care	Upon member presentation at service delivery site, including non-network and out-of-area facilities
Urgent care, including urgent specialty care	Provided within 24 hours of request
Routine primary care	Provided within 14 days of request
Routine specialty care referrals	Provided within 30 days of request
Initial outpatient behavioral health visit	Provided within 14 days of request
Routine prenatal care	Provided within 14 days of request or immediately if an emergency exists.
Prenatal care for high-risk pregnancies or new members in third trimester	Appointment offered within 5 days, or immediately if an emergency exists.
Preventive health care services for children	Offered in accordance with Texas Health Steps Periodicity Schedule
Newborns	In no case later than 14 days of enrollment of Texas Health Steps Periodicity Schedule
Existing member overs 36 months annual checkup within 364 days of birthday	Provided within 90 days of request
Initial outpatient behavioral health visits upon discharge from an inpatient psychiatrist setting	Provided within 7 days of request
New member	Provided within 90 days of request
Community-based services for Non-MDCP STAR Kids waiver members	Initiated 7 days from the date the MCO authorizes services unless the referring provider or member states otherwise

SECTION IV. PROVIDER RESPONSIBILITIES

Emergency Prescription Supply

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

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

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

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

- "8" in "Prior Authorization Type Code" (Field 461-EV)
- "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-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.

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

Emergency Transportation—Ambulance

Ambulance transport is an emergency service when the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence of immediate medical attention could result

in serious impairment, dysfunction, or failure of 1 or more organs or body parts and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

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/tmppm>.

Non-emergency Transportation—Medical Transportation

When a Texas Children's Health Plan member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is a non-emergency service. Non-emergency transports for a Texas Children's Health Plan member with severe disabilities must be to or from a scheduled medical appointment. A round-trip transfer from the member's home to an outpatient or freestanding dialysis or radiation facility is covered only when the member meets the definition of severely disabled. Severely disabled means that the member's physical condition limits his/her mobility and requires the member to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems, including oxygen or IV infusion. A run sheet or other supporting documentation is required for non-emergency transportation and must clearly state the member's physical condition and severity at the time of the transfer. The run sheet must include the signature of the EMT transporting the client. Non-emergency transfers of members whose condition does not meet the severely-disabled criteria are not covered benefits.

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
- Logistics of trip (will they have a guardian/

SECTION IV. PROVIDER RESPONSIBILITIES

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.

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 Transportation Services with Veyo, please refer them to Veyo at **1-888-401-0170** to schedule a ride.

Transportation Value-Added Services

Additional transportation—if transportation is a barrier to attending medical visits, Texas Children’s Health Plan will, upon verification of medical appointments, arrange for transportation through taxi voucher or bus. If member has access to private vehicle transportation, Texas Children’s Health Plan may offer a prepaid gasoline card to reimburse for mileage.

Medicaid Emergency Dental Services

Texas Children’s Health Plan is responsible for emergency dental services provided to Medicaid Members in a hospital, free standing emergency room, or an ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) including but not limited to:

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

craniofacial anomalies and drugs.

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 6 through 35 months.

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

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member’s Main Dental Home choice in the Members’ file.

Texas Children’s Health Plan **is responsible** for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Texas Children’s Health Plan reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children and young adults (birth through age 20), Texas Children’s Health Plan also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products including supplements and vitamins.

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

SECTION IV. PROVIDER RESPONSIBILITIES

20), a pharmacy must first enroll in our Network by contacting Navitus at **1-866-333-2757** or via e-mail at providerrelations@navitus.com. Pharmacies will submit pharmacy claims to Navitus. Call Navitus Provider line at **1-866-333-2757** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

Texas Children's Hospital covers all outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals through formularies and a preferred drug list (PDL) developed by HHSC and available on the Vendor Drug website at <http://www.txvendordrug.com/>

Durable Medical Equipment /Diabetic Supplies

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 nebulizer, 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, but not covered as a pharmacy benefit for children (birth through age 20), a pharmacy must:

- Enroll with the MCO to become a Medicaid-enrolled DME provider.
- 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 www.txvendordrug.com.
 - Pharmacies do not have to be enrolled as DME providers to submit claims for these supplies.

ELECTRONIC VISIT VERIFICATION

What is Electronic Visit Verification (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;
- 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 claims.

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, 2024.

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 on the HHSC EVV website. <https://www.tmhp.com/topics/evv/evv-proprietary-systems>

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.

SECTION IV. PROVIDER RESPONSIBILITIES

- **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 Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system: <https://www.tmhp.com/topics/evv/evv-proprietary-systems>
- **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, 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>

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 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 in the EVV TRAINING section below; 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.

SECTION IV. PROVIDER RESPONSIBILITIES

- 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 approved by the state.
- 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.

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

SECTION IV. PROVIDER RESPONSIBILITIES

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;
 - 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. Note, if a Service Provider or CDS Employee are unable to use a mobile method in the community, they must manually enter their clock in and/or clock out times in the EVV System.

(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 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 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.

SECTION IV. PROVIDER RESPONSIBILITIES

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 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, FMSAs, or CDS Employers 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. 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 Provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

Visit <https://www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook/appendix-i-evt-reason-codes-table>

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 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:

SECTION IV. PROVIDER RESPONSIBILITIES

- EVV System training provided by EVV vendor or EVV PSO; and
- EVV Policy training provided by 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 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.

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. The MCO will conduct reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:

- Meet the minimum EVV Usage Score;
- Document EVV required free text; and
- Ensure valid phone type is used.

The Texas Children's Health Plan compliance plan is located at www.Texaschildrenshealthplan.org

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 HHSC's Claims Administrator in accordance with the MCO's submission requirements.

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

If a Provider or FMSA submits an EVV claim to the MCO instead of the Claims Administrator, the MCO will reject

or deny the claim and require the Provider or FMSA to submit the claim to the Claims Administrator.

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

Each claims management system 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 claims management system for further claims processing. After completing the EVV claims matching process, the Claims Administrator forwards the claim to the MCO for final processing.

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 found on the HHSC EVV website 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

SECTION IV. PROVIDER RESPONSIBILITIES

- 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 if the claim line item 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.

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 the results of the claims matching process and 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.

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 V. PROVIDER COMPLAINTS AND APPEALS

PROVIDER COMPLAINTS TO TEXAS CHILDREN'S HEALTH PLAN

Provider Complaints Process to MCO as a STAR Kids health plan, it is the policy of Texas Children's Health Plan to adhere to State Medicaid Provider Guidelines as defined in the current edition of the Texas Medicaid Provider Procedures Manual. A complaint includes any dissatisfaction with any aspect of Texas Children's Health Plan's operations, including plan administration, the appeal of an adverse determination, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions, may file a complaint or appeal with Texas Children's Health Plan. The following information will assist providers in filing.

How to Submit Complaints Online

Providers may submit complaints online through email link on the Texas Children's Health Plan provider portal texaschildrenshealthplan.org/for-providers or by using the Provider Concern email box at TCHPProviderConcerns@TCHP.us

How to Submit Complaints via Paper

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

Texas Children's Health Plan
Attention: Provider & Care Coordination
Provider and Care Coordination NB 8301
PO Box 301011
Houston, TX 77230-1011
832-828-1008

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

Provider appeals will be responded to within 30 calendar days of receipt. If a provider appeal involves a presently occurring emergency, denial of a continued hospital

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

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

Documentation

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

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

SECTION V. PROVIDER COMPLAINTS AND APPEALS

PROVIDER APPEAL TO TEXAS CHILDREN'S HEALTH PLAN

All appeals of denied claims and requests for adjustments on paid claims must be received by Texas Children's Health Plan within 120 days from the last date of disposition; the date of the Explanation of Benefits on which that claim appears. Notification of Receipt of the request for an appeal will be sent to the provider within 5 business days of receipt of the request. Provider appeals will be responded to within 30 calendar days of receipt. If a provider appeal involves a presently occurring emergency, denial of a continued Hospital stay, or life-threatening condition, Texas Children's Health Plan shall respond in accordance to the medical immediacy of the case but in no event, greater than 1 business day from the time Texas Children's Health Plan receives the appeal. Texas Children's Health Plan will provide an oral resolution decision within 1 business day of receipt of an expedited appeal and in writing within 3 business days. All provider appeals involving medical necessity issues will be made by a physician. If an appeal is denied, the provider has 30 working days to set forth in writing good cause for having a particular type of specialty provider review the case, and the denial shall be reviewed by a provider in the same or related specialty as the appealing provider. An acknowledgement letter will be sent within five working days of receiving request for specialty review. Specialty review will be completed within 15 working days of receipt of request.

Claims lacking the information necessary for processing are listed on the Explanation of Benefits requesting the missing Information. Providers must resubmit a completed/corrected claim to Texas Children's Health Plan within 120 days from the date of the Explanation of Benefits to be considered for payment.

Texas Children's Health Plan is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal

How to Submit Appeals via Paper

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

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

Providers must utilize the Claims Appeal/Resubmission Form for all claims, resubmissions, and appeals.

How to Submit Appeals via Provider Portal

For Appeals: Submission of appeals for STAR Kids is available via the Texas Children's Health Plan portal.

Please contact Texas Children's Health Plan Provider Relations Department **1-800-731-8527**.

Documentation

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

- Both the provider and Texas Children's Health Plan will retain all documentation including fax cover sheets, emails, telephone log of communication related to the expression of dissatisfaction.

Provider Complaints to Texas Health and Human Services Commission

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

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

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

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

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.

SECTION V. PROVIDER COMPLAINTS AND APPEALS

- 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-9IX
PO Box 204077
Austin, Texas 78720-4077**

SECTION VI. MEMBER COMPLAINTS AND APPEALS

MEMBER'S RIGHT TO FILE COMPLAINTS WITH TEXAS CHILDREN'S HEALTH PLAN AND HHSC

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

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

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

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

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

How to File a Complaint

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

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

Assistance and Filing Process

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

Texas Children's Health Plan will send the complainant a letter acknowledging receipt of the oral or written complaint within 5 business days. The letter will contain a description of Texas Children's Health Plan's complaint process and timeframes for processing. Texas Children's Health Plan will investigate the complaint and send the member a resolution letter within 30 calendar days following receipt of the complaint.

Timeframe for Filing a Complaint

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

Timeframe for Resolution of a Complaint

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

Once the complaint has been resolved, the member advocate will send a response letter to the member or member's authorized representative with the resolution of the complaint.

Member's Right to Appeal an Action

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

An action includes:

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

SECTION VI. MEMBER COMPLAINTS AND APPEALS

HOW TO FILE AN APPEAL

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

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

If a member needs assistance filing an appeal, he or she may call Texas Children's Health Plan Member Services at **832-828-1001** or toll-free at **1-866-959-2555**. A member advocate is available to provide assistance and explain the appeal process. Texas Children's Health Plan will send the appellate a written acknowledgement letter within 5 business days. If a member files an oral appeal, Texas Children's Health Plan will send with the written acknowledgement letter an appeal form.

The appellate must complete and return the appeal form to document the appeal in writing. The appeal request must be signed by the member or their authorized representative.

Timeframe for Filing an Appeal

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

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

If the appeal decision is adverse to the member, the member may be financially responsible for the services which were the subject of the appeal. After going through the Texas Children's Health Plan appeal

process, a member also has the right to request a State Fair Hearing. The member has 120 days from the date of the appeal decision letter to request a State Fair Hearing.

Timeframe for Resolution of an Appeal

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

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

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

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

Right to an Emergency MCO Appeal

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

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

How to File an Expedited Appeal

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

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

Texas Children's Health Plan will accept expedited appeals 24 hours a day, 7 days a week. Members or their representatives should provide information supporting the request for an expedited appeal. Assistance in filing an expedited appeal may be obtained by contacting Texas Children's Health Plan Member Services at **832-828-1001** or

SECTION VI. MEMBER COMPLAINTS AND APPEALS

1-866-959-2555. A member advocate is available to provide assistance.

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

Resolution Timeframe for an Expedited MCO Appeal

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

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

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

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

STATE FAIR HEARING INFORMATION

Can 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 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:

**Texas Children's Health Plan
Attention: Appeals Department
PO Box 300709
Houston, TX 77230
832-828-1008**

or call Texas Children's Health Plan at 832-828-1008 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 an State Fair Hearing no later than 120 days after Texas Children's Health Plan mails the appeal decision notice

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:

SECTION VI. MEMBER COMPLAINTS AND APPEALS

- 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 1-800-659-5764;
- Email Texas Children's Health Plan at TCHPUM@texaschildrens.org.

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision 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 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. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that 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 VII. MEMBER ELIGIBILITY AND ADDED BENEFITS

ENROLLMENT

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

VERIFYING MEMBER MEDICAID ELIGIBILITY AND TEXAS CHILDREN'S HEALTH PLAN ENROLLMENT

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

- Log in to your TMHP user account and access Medicaid Client Portal for providers.
- Use TexMedConnect on the TMHP website at www.tmhp.com
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **1-800-925-9126** or **1-512-335-5986**.
- Call Provider Services at the patient's medical or dental plan.

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling **1-800-252-8263**. Medicaid Members also can go online to order new cards or print temporary cards.

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

Providers access to Medicaid medical and dental health information

Medicaid providers can log in to their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid client's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.
- Enhanced eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information.
- A viewable and printable Medicaid card.
- Display of the Tooth Code and Tooth Service Code for Dental Claims or encounters.
- Display of the last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card.
- See their medical and dental plans.
- See their benefit information.
- See Texas Health Steps Alerts.
- See broadcast alerts.
- See diagnosis and treatments.
- See vaccines.
- See prescription medicines.
- Choose whether to let Medicaid doctors and staff see their available medical and dental information.

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active clients only. Legally Authorized Representatives can view anyone who is part of their case.

Your Texas Benefits STAR Kids Medicaid Card and STAR Kids Medicaid Verification Form 1027-A

The Your Texas Benefits STAR Kids Medicaid Card and Medicaid Verification Form 1027-A will indicate the member is enrolled in Texas Children's Health Plan. The name and Medicaid number of each STAR member in the household/case will also appear on the form. Providers must review limitations identified on the member's Your Texas Benefits Medicaid Card or their Medicaid Eligibility Verification Form 1027-A. Members may be limited to one primary provider or pharmacy. Only those members listed on the STAR

SECTION VII. MEMBER ELIGIBILITY AND ADDED BENEFITS

Kids Medicaid identification form are eligible for STAR Kids Medicaid.

Texas Children's Health Plan Identification Card

Texas Children's Health Plan issues a Texas Children's Health Plan identification card (ID) to all its members. When a Texas Children's Health Plan member visits your office, make a copy of both sides of the Texas Children's Health Plan ID Card for your records. Please note that while the Texas Children's Health Plan ID Card identifies a Texas Children's Health Plan member, it does not confirm eligibility or guarantee benefit coverage or payment. If a member presents only his or her Texas Children's Health Plan ID Card to identify his or her health plan and cannot provide a Your Texas Benefits Medicaid Card, providers should then verify the member's current eligibility status through Texas Children's Health Plan. Providers must document this verification in their records and treat these members as if they had presented a Your Texas Benefits STAR Kids Medicaid Card or Medicaid Eligibility Verification (Form I027).

If a member insists he or she is eligible for STAR Kids Medicaid but cannot produce a Your Texas Benefits Medicaid Card or a Texas Children's Health Plan ID card, providers can verify eligibility through Texas Children's Health Plan at **1-866-959-2555** or TMHP Contact Center at **1-800-925-9126**. Providers must document this verification in their records and treat these members as if they had presented a Your Texas Benefits STAR Kids Medicaid Card or Medicaid Eligibility Verification (Form I027).

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

Front:

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

Back:

- Claims address
- Information needed to submit electronic claims

STAR KIDS DUAL MEMBER ID CARD

**Texas Children's
Health Plan**

**TEXAS
STAR Kids**
Your Health Plan • Your Choice

TEXAS
Health and Human
Services

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 **1-800-659-5764**
Nurse Help Line 24/7 Línea telefónica de enfermería 24/7 .. **1-800-686-3831 (TDD): 1-800-735-2989**
Behavioral Health & Substance Abuse 24/7
 Línea telefónica de salud mental y abuso de sustancias 24/7 **1-844-818-0125**
Vision Care Cuidado de la visión **Enroll Vision: 1-844-212-7269**
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. LONG-TERM SUPPORTS AND SERVICES AND LONG-TERM CARE BENEFITS ONLY; You receive primary, acute and behavioral health services through Medicare. You receive only long-term care services through Texas Children's Health Plan.

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. SERVICIOS Y APOYOS A LARGO PLAZO Y BENEFICIOS DE ATENCIÓN A LARGO PLAZO ÚNICAMENTE: Usted recibe atención primaria, aguda y servicios de salud mental a través de Medicare. Usted recibe únicamente servicios de atención a largo plazo a través de Texas Children's Health Plan.

©2021 Texas Children's Health Plan 05/21

For eligibility, authorizations, benefits, and claims call Provider and Care Coordination: 832-828-1004
Submit claims to: PO Box 300286 Houston, TX 77230
Electronic Claims Filing Number: WebMD: 75228, THIN: TXCSM, Legacy: 76048

This non-transferable card is for identification; it does not guarantee coverage.

texaschildrenshealthplan.org MS-2105-205

Medicare

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

Options to verify eligibility:

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

ADDED BENEFITS

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

- STAR Kids clients are not limited to the 30-day spell of illness

SECTION VII. MEMBER ELIGIBILITY AND ADDED BENEFITS

- \$200,000 annual limit on inpatient services does not apply
- Unlimited medically necessary prescription drugs

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

Benefit is only available for Members who are NOT covered by Medicare.

STAR Kids Value-added Services

Members can access the services by calling Member Services at toll free **1-800-659-5764**.

- Additional transportation
- Gasoline cards will generally be limited to \$20.00 or less (based on actual mileage). Gasoline will be a prepaid card limited to gasoline purchases only
- Extra help with getting a ride for doctor visits
- Respite care- The value added respite care service will be limited to eight hours of in-home services per year and must be approved and preauthorized by Texas Children's Health Plan's Service Coordination department.
- 8-hour Caregiver Respite Care Services
- The value-added sports team, will be limited to four games per year for ages 5 to 20
- Sports team based on availability
- Tobacco dependent parents of all health plan members who agree to coaching by a service coordinator or health educator. Enrolled in a smoking cessation-counseling program. Up to four family members.
- Smoking cessation benefits for tobacco dependent parents
- Pest Control- The member must be participating in Texas Children's Health Plan's Disease Management program for a minimum of three months and the Member's family must own/rent a home. STAR Kids Members with asthma who have been hospitalized or received emergency room treatment in the past 90 days will be considered for this program. This value-added service will be limited to twice per year.
- Parent training- This value-added service will be limited to \$100 per family per year. Based on availability.
- Sensory-Friendly films- The only limitation is the location of the theater that provides this service
- 24 Hour Nurse Help Line
- Post hospitalization follow up visit incentive- STAR Kids member only. Gift card will be mailed to member upon receipt of post hospitalization follow up visit. Gift cards will be limited to \$25 and not to exceed 3 gift cards per member per calendar year.

SECTION VIII. MEMBERS RIGHTS AND RESPONSIBILITIES

Members 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.
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. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program. (see page 17, MDCP/DBMD Escalation Help Line).
 - c. Get a timely answer to your complaint.
 - d. Use the plan's appeal process and be told how to use it.
 - e. Ask for a an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
 - f. 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.

SECTION VIII. MEMBERS RIGHTS AND RESPONSIBILITIES

Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Members Responsibilities

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

what health care is best for you.

- b. Understand how the things you do can affect your health.
- c. Do the best you can to stay healthy.
- d. Treat providers and staff with respect.
- e. Talk to your provider about all of your medications.

Members Right to Designate an OB/GYN (STAR Kids Dual Eligible Members are excluded.)

Option 1: MCO DOES NOT LIMIT TO NETWORK

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

ATTENTION FEMALE MEMBERS

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

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

FRAUDS INFORMATION:

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE

Let us know if you think a doctor, dentist, pharmacy and/or 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 weren't 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

SECTION VIII. MEMBERS RIGHTS AND RESPONSIBILITIES

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, or;
- You can report directly to Texas Children’s Health Plan:

Email: TCHPSIU@texaschildrens.org

Fax: 832-825-8722

Mail: Texas Children’s Health Plan, Controls and Compliance Department
PO Box 301011
Houston, TX 77230-1011
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
- 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
- Specific details about the potential fraud, waste and/or abuse

SECTION IX. BILLING AND CLAIM ADMINISTRATION

CLAIMS FILING

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

Please submit claims for the following services to:

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

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

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

LONG-TERM SERVICES AND SUPPORTS (LTSS) 1915(c) waivers

CLASS Services

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

DBMD Services

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

HCS Services

Adaptive Aids
Employment Assistance
Financial Management Services

Minor home modification
Respite
Supported Employment
Residential services

TxHmL Services

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

YES Services

Adaptive Aids
Employment Assistance
Minor home modification
Respite
Supported Employment
Family supports
Non-medical transportation
Paraprofessional services
Pre-engagement services
Specialized therapies
Supportive family-based alternatives
Transitional services

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

- a) Texas Children's Health Plan is not responsible for providing payments to a Nursing Facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities or other related condition (ICF/IID), but will provide Acute Care and Service Coordination to a Member residing in a Nursing Facility or an ICF/IID if the services are not provided through the Nursing Facility or ICF/IID as part of the daily rate.
- b) If a Texas Children's Health Plan member changes MCOs prior to the delivery of their custom DME and augmentative devices, with the appropriate authorization the new MCO will be responsible for the claim. TCHP will be responsible for previously authorized custom DME and augmentative devices authorized by another MCO when that member becomes a TCHP member if the delivery occurs after the new enrollment with TCHP. In cases where TCHP may have denied a custom DME and

SECTION IX. BILLING AND CLAIM ADMINISTRATION

augmentative device and a State Fair Hearing Officer reverses the decision, TCHP will be responsible for the cost of the custom DME service/equipment from the date of original denial.

- c) If a Texas Children's Health Plan MDCP STAR Kids Waver member changes MCOs before completion of a minor home modification, Texas Children's Health Plan will cover the minor home modifications. All other services will be covered by the new MCO.

Provider Portal Functionality

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

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

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

Claims Submission Form/Format

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

TCHP Billing Requirements for LTSS Services

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

Please note that some PDN services are classified as acute rather than LTSS.

For all provider services, each date of service for each procedure rendered must be billed on a separate claim line. Multiple dates of services, may not be combined on a single claim line on professional or outpatient claims.

Monthly Capitation Services

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

Emergency Services Claims

Emergency services means covered inpatient and

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

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

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

There are no co-payments for STAR Kids members.

Coordination of Benefits with Third Party Resources, to include Medicare for Dual Eligible STAR Kids Members
Texas Children's Health Plan coordinates with all primary payers including Medicare Dual Eligibles.

Member Acknowledgement Statement

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

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

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

SECTION IX. BILLING AND CLAIM ADMINISTRATION

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

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

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

Private Pay Agreement Form

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

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

PRIVATE PAY AGREEMENT

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

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

Signed: _____

Dated: _____

PACTO DE PAGO PRIVADO

Yo, _____ entiendo que el proveedor _____ me esta aceptando como paciente

de pago privado por el periodo de _____, y me hago responsable en pagar por cualquier servicio rendido.

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

Nombre: _____

Fecha: _____

SECTION IX. BILLING AND CLAIM ADMINISTRATION

Time Limit for Submission of Claims

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

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

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

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

Clean Claims Payment for Professional and Institutional Claim Submission

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

Once a clean claim is received, TCHP is required, within the 30 day claim payment period, to:

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

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

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

Clean Claims Payment on Pharmacy Claim Submission

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

SECTION IX. BILLING AND CLAIM ADMINISTRATION

APPROVED CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																					
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)													
CITY			STATE		8. RESERVED FOR NUCC USE			CITY													
ZIP CODE			TELEPHONE (Include Area Code) ()					ZIP CODE													
								TELEPHONE (Include Area Code) ()													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY											
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY					15. OTHER DATE QUAL. MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					17b. NPI					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E))										ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.							
A. _____ B. _____ C. _____ D. _____																					
E. _____ F. _____ G. _____ H. _____																					
I. _____ J. _____ K. _____ L. _____																					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()											
SIGNED					DATE					a. NPI		b. NPI									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SECTION IX. BILLING AND CLAIM ADMINISTRATION

APPROVED CLAIM FORM

1										2										3a PAT. CNTRL. #					4 TYPE OF BILL														
																				b. MED. REG. #																			
																				5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM					7 THROUGH									
8 PATIENT NAME										9 PATIENT ADDRESS																													
b										c										d					e														
10 BIRTHDATE			11 SEX		12 DATE			13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES					29 ACDT STATE		30						
31 OCCURRENCE DATE			32 OCCURRENCE DATE			33 OCCURRENCE DATE			34 OCCURRENCE DATE			35 CODE			OCCURRENCE SPAN FROM			THROUGH			36 CODE			OCCURRENCE SPAN FROM			THROUGH			37									
38										39 CODE					VALUE CODES AMOUNT					40 CODE					VALUE CODES AMOUNT					41 CODE					VALUE CODES AMOUNT				
a										b					c					d																			
b										c					d																								
c										d																													
d																																							
42 REV. CD.		43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49									
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
7																																							
8																																							
9																																							
10																																							
11																																							
12																																							
13																																							
14																																							
15																																							
16																																							
17																																							
18																																							
19																																							
20																																							
21																																							
22																																							
23																																							
PAGE ____ OF ____										CREATION DATE										TOTALS																			
50 PAYER NAME										51 HEALTH PLAN ID										52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI											
A										B										C		D		E		F													
B										C										D		E		F		G													
C										D										E		F		G		H													
58 INSURED'S NAME										59 P. REL.		60 INSURED'S UNIQUE ID								61 GROUP NAME				62 INSURANCE GROUP NO.															
A										B		C								D				E															
B										C		D								E				F															
C										D		E								F				G															
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																			
A										B										C																			
B										C										D																			
C										D										E																			
66 DX		67		A		B		C		D		E		F		G		H		68																			
I		J		K		L		M		N		O		P		Q																							
69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		73																									
74 PRINCIPAL PROCEDURE CODE		DATE		a.		OTHER PROCEDURE CODE		DATE		b.		OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		QUAL																			
LAST		FIRST				LAST		FIRST				LAST		FIRST				LAST		FIRST																			
c.		OTHER PROCEDURE CODE		DATE		d.		OTHER PROCEDURE CODE		DATE		e.		OTHER PROCEDURE CODE		DATE		77 OPERATING NPI		QUAL																			
LAST		FIRST				LAST		FIRST				LAST		FIRST				LAST		FIRST																			
80 REMARKS				81CC a		b		c		d								78 OTHER NPI		QUAL																			
LAST		FIRST				LAST		FIRST				LAST		FIRST				LAST		FIRST																			
B		C		D		E		F		G		H		I		J		K		L																			
C		D		E		F		G		H		I		J		K		L		M																			
D		E		F		G		H		I		J		K		L		M		N																			
E		F		G		H		I		J		K		L		M		N		O																			
F		G		H		I		J		K		L		M		N		O		P																			
G		H		I		J		K		L		M		N		O		P		Q																			
H		I		J		K		L		M		N		O		P		Q		R																			
I		J		K		L		M		N		O		P		Q		R		S																			
J		K		L		M		N		O		P		Q		R		S		T																			
K		L		M		N		O		P		Q		R		S		T		U																			
L		M		N		O		P		Q		R		S		T		U		V																			
M		N		O		P		Q		R		S		T		U		V		W																			
N		O		P		Q		R		S		T		U		V		W		X																			
O		P		Q		R		S		T		U		V		W		X		Y																			
P		Q		R		S		T		U		V		W		X		Y		Z																			
Q		R		S		T		U		V		W		X		Y		Z																					
R		S		T		U		V		W		X		Y		Z																							
S		T		U		V		W		X		Y		Z																									
T		U		V		W		X		Y		Z																											
U		V		W		X		Y		Z																													
V		W		X		Y		Z																															
W		X		Y		Z																																	
X		Y		Z																																			
Y		Z																																					
Z																																							

SECTION IX. BILLING AND CLAIM ADMINISTRATION

CLAIMS APPEAL FORM



**Texas Children's[®]
Health Plan**

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 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/Recoupment/Offset |
| <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 appeals can be submitted via Provider TouCHPoint Portal:
www.texaschildrenshealthplan.org

Appeals can be sent via US mail or faxed to:
844-386-3171
Texas Children's Health Plan
PO Box 300286
Houston, TX 77230-0286

Revised 04/10/17

CL-0712-002

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

SECTION IX. BILLING AND CLAIM ADMINISTRATION

Payment/Accrual of interest by Texas Children's Health Plan

Texas Children's Health Plan will pay penalty and interest for clean claims submitted more than 30 days.

Allowable Billing Methods

Electronic billing, and paper.

Special Billing (Newborns, Value Added Services, SSI Compounded Medications, NEMT Services, etc.)

Please contact Texas Children's Health Plan Provider Relations for special billing at **832-828-1008** or toll free at **1-800-731-8527**.

Claims Questions/Appeals

Please contact Texas Children's Health Plan at **832-828-1004** or toll free or toll free at **1-877-213-5508**.

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

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

How to find a list of covered drugs

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

How to find a list of preferred drugs

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

Process for Requesting a Prior Authorization (PA)

All out-of-network services, except emergency services, require prior authorization. Please contact the Texas Children's Health Plan Provider and Care Coordination Department or the Utilization Management Program at **1-832-828-1004 option 5** or toll free at **1-800-731-8527** for the most current prior authorization requirements.

AUTHORIZATION FOR HEALTH SERVICES

The primary care provider acts as the coordinator for health care provided to Texas Children's Health Plan STAR Kids members, both within and outside of the primary care provider's office. The primary care provider has the primary responsibility for arranging and coordinating appropriate referrals to other providers/specialists, as well as managing and coordinating the

administrative functions related to the delivery of health services in conjunction with Texas Children's Health Plan and case managers as indicated.

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

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

Authorizations for in-network specialists are not required.

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

The following services require authorizations:

Medical Authorizations

- All out-of-network services
- Ambulance services (non-emergent transport)
- Augmentative Communication Devices
- Baclofen injections/pump
- Bariatric Surgery
- Botox Injections
- Chemotherapy non-FDA approved
- Circumcision greater than 1 year of age
- Cochlear Implant
- Contact lenses due to disease process
- Cosmetic Surgery
- Cranial Molding Orthosis (Helmets)
- Dental Medically necessary (except for cleft palate)
- Gait trainer
- All genetic testing
- Home Health Care
- Hospital grade Blood Pressure Monitors in home use
- Hospital Beds and accessories
- Hospital Inpatient care
- Nutritional Supplements
- Oral Surgery
- Organ Acquisition
- PET Scans
- Prescribed Pediatric Extended Care Centers

SECTION IX. BILLING AND CLAIM ADMINISTRATION

- Private Duty Nursing in home
- Progesterone Therapy
- Prosthetics
- Skilled Nursing facility
- SPECT Scans
- Therapy – Physical, Occupational, Speech (including initial Eval)
- TMJ diagnosis and treatment
- Transplant Evaluation
- Vision Care, medically necessary
- Wheelchairs and accessories

Behavior Health Authorizations

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

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

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

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

Authorization of Clinician-Directed Care Coordination for Medically Complex Members

1. Services require an authorization by the member's Texas Children's Health Plan case manager.
2. Authorization must be obtained within 7 days of the initial date of service.

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

Definitions of medically complex and multidisciplinary care are defined by Texas Children's Health Plan as documented in the Texas Medicaid Bulletin, No. 209 p. 163.

Calls for authorization may be placed at **832-828-1004** or toll free at **1-877-213-5508**. Failure to comply with this process may result in nonpayment of claims. If you need further assistance or clarification, please contact your provider relations manager or call the Provider Relations telephone line at **832-828-1008** or toll free at **1-800-731-8527**.

How to find a list of PA Required Services and Codes

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

SECTION IX. BILLING AND CLAIM ADMINISTRATION

Prior Authorization Determinations

Texas Children's Health Plan 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.

Prior Authorization Fax Lines

- Medical Services Fax Line - 832-825-8760 or Toll-Free 1-844-473-6860
- Behavioral Health Services Fax Line - 832-825-8767 or Toll-Free 1-844-291-7505
- LTSS and Private duty Nursing Fax Line - 346-232-4757 or Toll-Free 1-844-248-1567
- Medical Inpatient Admissions and Discharge Notifications - 832-825-8462 or Toll-Free 844-663-7071
- Post Hospital Discharge Authorizations Fax Line - Toll-Free 866-839-9879

Authorization Type	Turn Around Timeline
Routine	3 business days
Urgent	1 business day
Inpatient	1 business day
Life-threatening conditions	Within one hour

- TCHP does not require prior authorization for Emergency Medical Conditions or Emergency Behavioral Health Conditions
- Post hospital discharge services | within one business day

Resources:

Hospital Inpatient Care Guidelines: [https://www.texaschildrenshealthplan.org/sites/default/files/pdf/Hospital Inpatient Care Guidelines Nov%202021.pdf](https://www.texaschildrenshealthplan.org/sites/default/files/pdf/Hospital%20Inpatient%20Care%20Guidelines%20Nov%202021.pdf)

Prior Authorization Information: <https://www.texaschildrenshealthplan.org/for-providers/provider-resources/prior-authorization-information>

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 the Texas Children's health plan's Provider Portal at: [texaschildrenshealthplan.org/for-providers](https://www.texaschildrenshealthplan.org/for-providers).

Texas Children's Health Plan may extend the timeframe for a standard authorization decision by up to 14

calendars days if the member or provider requests an extension.

Texas Children's Health Plan may also extend the timeframe 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.

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.

Provider Portal

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

Continuity of Care and Out of Network Provider Requirements

Texas Children's Health Plan must ensure that the healthcare of newly enrolled Members is not disrupted, compromised, or interrupted. The Health Plan must take special care to provide continuity in the care of enrolled Members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted.

- Pregnant women information—Texas Children's Health Plan will take special care not to disrupt care in progress for newly enrolled members. Pregnant members with 12 weeks or less of their pregnancy remaining before expected delivery date will not be disrupted from their current OB/GYN provider (even if the provider is out of network) through the member's postpartum checkup. A member may change her OB/GYN if she requests.

SECTION IX. BILLING AND CLAIM ADMINISTRATION

- Newborn Inpatient Coverage—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.
- 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.
- Member moves out of service area—Texas Children's Health Plan requests that the member tell us in writing if they move, change their address or phone number, even if these changes are temporary. If a member moves out of the service area, they may no longer be eligible. Texas Children's Health Plan will provide or pay out-of-network providers who provide medically necessary covered services to members who move out of the service area through the end of the period for which capitation has been paid for the member.
- Texas Children's Health Plan does not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Texas Children's Health Plan STAR Kids member.

The Health Plan is required to ensure that clients receiving Community-Based Services prior to the Operational Start Date continue to receive those services for up to six months after the Operational Start Date, unless the Health Plan has completed the STAR Kids Screening and Assessment Process and issued new authorizations as described in Section 8.1.39. During the Transition Phase an HHS Agency will provide a file identifying these clients to the Health Plan for this purpose. The Health Plan must work with HHSC to ensure that all necessary authorizations are in place within the Health Plan's system(s) for the continuation of Community-Based Services. The Health Plan must describe the process it will use to ensure continuation of current Community-Based Services in its Transition/Implementation Plan as noted in Section 7.3.1. The Health Plan must ensure that Community-Based Service Providers are informed and

trained on this process prior to the Operational Start Date.

The Health Plan must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's 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 Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

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.

The Health Plan must pay a Member's existing Out-of-Network Providers for Medically Necessary and Functionally Necessary Covered Services and equipment and supplies until the Member's records, clinical information, and care can be transferred to a Network Provider, or until the Member is no longer enrolled in that Health Plan, whichever is shorter. If, at the time of enrollment, the Member has an existing scheduled appointment with an Out-of-Network specialist physician and the Health Plan does not arrange for an earlier alternative appointment with a Network Provider with a comparable certification, specialty, and expertise, the Health Plan must authorize and pay the Out-of-Network specialist physician for any Covered Service provided to the Member during that Member's scheduled appointment with the Out-of-Network specialist physician. If the Member requires follow-up care, the Health Plan may transfer the Member's care to a Network Provider with a comparable certification, specialty, and expertise, in coordination with the Out-of-Network specialist physician and the Member or the Member's LAR. Payment to Out-of-Network Providers must be made within the time period required for Network Providers. The Health Plan must comply with Out-of-Network Provider reimbursement rules as adopted by HHSC.

SECTION IX. BILLING AND CLAIM ADMINISTRATION

With the exception of pregnant Members who are past the 24th week of pregnancy, this requirement does not extend the obligation of the Health Plan to reimburse the Member's existing Out-of-Network Providers for on-going care for:

1. More than 90 days after a Member enrolls in the Health Plan, or
2. For more than 12 months in the case of a Member who, at the time of enrollment in the Health Plan, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the Health Plan.

The Health Plan's obligation to reimburse the Member's existing Out-of-Network Provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery.

The Health Plan must provide or pay Out-of-Network Providers who provide Medically Necessary Covered Services to Members who move out of the Service Area through the end of the period for which capitation has been paid for the Member.

The Health Plan must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The Health Plan will not be obligated to provide a Member with access to Out-of-Network services if the services become available from a Network Provider. If a Member's PCP or other Provider determines that disrupting a Member's existing relationship with an Out-of-Network Provider would subject the Member to unnecessary psychological or medical risk, the Health Plan must provide the Member access to those Out-of-Network services through an appropriate agreement with the Out-of-Network Provider.

The Health Plan must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network Provider, if a Network Provider is not available or does not have the clinical experience in a condition or treatment, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b) (3).The requirements in this Section 8.1.23

regarding access to and payment of Out-of-Network providers apply only to Out-of-Network providers who are enrolled Texas Medicaid providers.

SECTION X. DISENROLLMENT FROM HEALTH PLAN

ENROLLMENT

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

Newborn process

Newborns are presumed Medicaid eligible and enrolled in the mother's health care plan for at least 90 days from the date of birth. Newborns who have not received a state-issued Medicaid ID number will automatically receive a Texas Children's Health Plan assigned number effective on his or her date of birth.

If a newborn is born to a STAR Kids eligible mother, the HHSC administrative service contractor will enroll the newborn into the STAR program. All rules related to STAR newborn enrollment will apply to the newborn.

For STAR Kids dual members who have Medicare, a PCP is not listed on the Texas Children's Health Plan ID card. Instead, the phrase Long-term Services and Supports Benefits Only is listed. Medicare is responsible for primary, acute and behavioral health care services; therefore, the PCP's name, address and telephone number are not listed. The member receives only long-term services and supports through Texas Children's Health Plan.

AUTOMATIC RE-ENROLLMENT

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

Changing Health Plans

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

DISENROLLMENT

A member's disenrollment request will require medical documentation from the primary care provider or documentation that indicated sufficiently compelling circumstances that merit disenrollment.

Providers are prohibited from taking retaliatory action against a member. HHSC will make the final decision.

SECTION XI. SPECIAL ACCESS REQUIREMENTS

SPECIAL ACCESS

NEMT provides STAR Kids Members and their attendants' non-emergency transportation services to a reasonably close and medically appropriate provider in each HHSC region. Individuals who are currently STAR Kids Members have transportation to and from facilities that provide covered services when no other means of transportation is available to medical facilities to receive medically necessary covered services.

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

- Ambulance services- Ambulance services are covered for all members in emergencies. Severely disabled members whose conditions require ambulance services will be covered with prior approval.
- NEMT provides STAR Kids client's with transportation to medical offices and doctors for covered health services. This transportation is provided in the most cost-effective manner and at no cost to the Member.
- Members may use the service if they have a current STAR Kids ID and no others means of transportation.

NEMT requires a two-workday notice for most appointments, and mailing time should be allowed for bus tokens. NEMT is designed to improve access to medical care for Texas STARR clients. It is not for emergency or taxis services. Veyo, Texas Children's Health Plan's transportation provider can be reached at **1-888-401-0170** (toll free).

Interpreter/Translation Services

Texas Children's Health Plan provides language interpretation services to translate multiple languages. We do this through the Language Line which may be accessed by calling Member Services at **832-828-1001** or toll free at **1-866-959-2555**. Member Services will then contact the Language Line as a third-party conversation.

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

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

Health Plan will provide an approved interpreter from the American Sign Language Association.

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

Provider/Care Coordination

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

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

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

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

Reading /Grade Level Consideration

Patient materials should be written at a fourth- to sixth-grade reading level. The guidelines provided in this section for communication with interpreters are

SECTION XI. SPECIAL ACCESS REQUIREMENTS

also good guidelines for communicating with members with limited literacy, especially asking the member to repeat your instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines. Above all else, be sensitive to the embarrassment the member may feel about limited literacy.

Cultural Sensitivity

Cultural sensitivity refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each. Texas Children's Health Plan's interpretive services will help to provide care in

culturally competent manner.

Texas Children's Health Plan has a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician.

Telemedicine, Telehealth, and Telemonitoring Access

Telemedicine, telehealth, and telemonitoring are Covered Services and are benefits of Texas Medicaid as provided in the Texas Medicaid Provider Procedures Manual.

SECTION XII. APPENDIX

ATTACHMENT A – PRIMARY CARE BY SPECIALIST REQUEST FORM 79

**ATTACHMENT B – TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM
FOR HEALTH CARE SERVICES 80**

ATTACHMENT C – PROVIDER INFORMATION CHANGE FORM 82

ATTACHMENT D – MEMBER ID CARD. 83

ATTACHMENT E – CLAIM APPEAL FORM 84

ATTACHMENT F – MEMBER ACKNOWLEDGEMENT STATEMENT 85

ATTACHMENT G – PRIVATE PAY STATEMENT 86

ATTACHMENT H – COORDINATION OF CARE REFERRAL FORM. 87

SECTION XII. 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 XII. 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 XII. 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:
--------------	--------	------	-------

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 (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

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

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

Inpatient Outpatient Provider Office Observation Home Day Surgery Other: _____

Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehab Mental Health/Substance Abuse

Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

Home Health (MD Signed Order Attached? Yes No) (Nursing Assessment Attached? Yes No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

DME (MD Signed Order Attached? Yes No) (Medicaid only: Title 19 Certification Attached? Yes No)

Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

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

An issuer needing more information may call the requesting provider directly at: _____

SECTION XII. 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.

© 2020 Texas Children's Health Plan. All rights reserved. PR-1904-001 7/20

SECTION XII. APPENDIX

ATTACHMENT D – MEMBER ID CARD

STAR KIDS



STAR KIDS DUAL 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 **1-800-659-5764**
Nurse Help Line 24/7 Línea telefónica de enfermería 24/7 . . . **1-800-686-3831 (TDD); 1-800-735-2989**
Behavioral Health & Substance Abuse 24/7
 Línea telefónica de salud mental y abuso de sustancias 24/7 **1-844-818-0125**
Vision Care Cuidado de la visión **Envolv Vision: 1-844-212-7269**
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. LONG-TERM SUPPORTS AND SERVICES AND LONG-TERM CARE BENEFITS ONLY: You receive primary, acute and behavioral health services through Medicare. You receive only long-term care services through Texas Children's Health Plan.

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. SERVICIOS Y APOYOS A LARGO PLAZO Y BENEFICIOS DE ATENCIÓN A LARGO PLAZO ÚNICAMENTE: Usted recibe atención primaria, aguda y servicios de salud mental a través de Medicare. Usted recibe únicamente servicios de atención a largo plazo a través de Texas Children's Health Plan.

For eligibility, authorizations, benefits, and claims call Provider and Care Coordination: 832-828-1004
Submit claims to: PO Box 300286 Houston, TX 77230
Electronic Claims Filing Number: WebMD: 75228, THIN: TXCSM, Legacy: 76048

This non-transferable card is for identification; it does not guarantee coverage.

texaschildrenshealthplan.org
 ©2021 Texas Children's Health Plan 05/21 MS-2105-205

SECTION XII. 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 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/Recoupment/Offset |
| <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 appeals can be submitted via Provider TouCHPoint Portal:
www.texaschildrenshealthplan.org

Appeals can be sent via US mail or faxed to:
844-386-3171
Texas Children's Health Plan
PO Box 300286
Houston, TX 77230-0286

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

Revised 04/10/17
CL-0712-002

SECTION XII. 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 XII. 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: _____

SECTION XII. APPENDIX

Texas Children's Health Plan's Coordination of Care Referral Form

This member is currently receiving treatment and has consented to share information between their PCP and BH provider.

Date: _____

Member Name: _____ Date of Birth: _____

Reason for referral (if applicable): _____

The Patient is being treated for: _____

The patient has the following substance use problems: _____

The Patient is taking the following medications: _____

The patient has had the following adverse reactions to medications: _____

Current lab values: (may attach separate copies of lab results): _____

Circle One: Primary Care Provider Behavioral Health Provider

Clinician Name and License Type: _____

Clinician Signature: _____

Site/Clinic Name: _____

Address: _____

Phone: _____

Fax: _____

Date Completed: _____

Current Release of Information on file? Yes No Expiration:



Texas Children's[®] Health Plan

texaschildrenshealthplan.org
832-828-1008 or toll-free 1-800-731-8527

