Parkland
Community Health Plan

2025 Provider Manual
STAR Medicaid and CHIP

ParklandHealthPlan.com • 1-888-672-2277
Effective June 2025

Dallas Service Area: Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, Rockwall

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Dallas, TX 75247

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services

2025 Provider Manual TXP-15-09-01 (Rev 4/25)

PCHP retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by PCHP as proprietary and confidential. Please note: Material in this provider manual is subject to change. PCHP will post updates on **ParklandHealthPlan.com**

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Chapter 1: **Introduction**

Background

Welcome to Parkland Community Health Plan (PCHP). PCHP is pleased you are a part of our Provider network. PCHP believes hospitals, physicians, and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network.

PCHP is a leader in managed care services and lives through our mission to advance wellness, relieve suffering, develop, and educate.

PCHP's Provider Manual contains information to assist you in doing business with PCHP, Texas Medicaid, and CHIP programs.

Who is PCHP?

PCHP is a wholly owned subsidiary of Parkland Health and is a licensed health maintenance organization (HMO).

We are proud to be locally owned and operated solely in North Texas, dedicated to serving the public sector by providing coverage exclusively for low-income families, children, teens, pregnant women, and adults. PCHP offers Medicaid and CHIP in the Dallas Service Area, which consists of Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

Program Objectives

The Medicaid and CHIP Program consists of:

The **STAR program**, a Medicaid managed care program providing low-income children, pregnant women, and families with acute care medical assistance. The objectives of the program are to:

- Improve access to care for clients enrolled in the program
- Increase quality and continuity of care for clients
- Decrease inappropriate use of the health care delivery system, such as emergency rooms (ERs) for non-emergencies
- Achieve cost effectiveness and efficiency for the state
- Promote provider and client satisfaction

The **Children's Health Insurance Program (CHIP)**, which provides health coverage for children age 18 and younger in families that earn too much to qualify for Medicaid but

cannot afford private health care coverage. A child must be age 18 or younger, a Texas resident, a U.S. citizen or legal permanent resident and meet all income and resource guidelines. Objectives of the CHIP program are to:

- Increase the number of insured children in Texas.
- Ensure children have access to a medical home, a physician or health care provider who serves the physical, mental, and developmental health care needs of a growing child through a continuous and ongoing relationship.

Texas residents who are pregnant, uninsured, and not able to obtain Medicaid may be eligible for CHIP Perinatal benefits. Coverage starts before the child is born and lasts 12 months from the date the unborn child is enrolled. The objectives of CHIP Perinatal are to improve health status and birth outcomes by ensuring pregnant women who are ineligible for Medicaid due to income or immigration status receive prenatal care.

Quick Reference Guide

PCHP Contacts	Phone Number or Information
Provider Services	1-888-672-2277
Member Services	**STAR Medicaid:** 1-888-672-2277 **CHIP/CHIP Perinate:** 1-888-814-2352
24-Hour Nurse Line	**STAR:** 1-888-667-7890 or 214-266-8773 **CHIP/CHIP Perinate:** 1-800-357-3162 or 214-266-8766
24-Hour Behavioral Health Hotline	1-844-603-1134
Service Coordination and Condition Management	214-393-7003
Claim Inquiries / Status	**Electronic claims submission:** **Payer ID # 66917** To submit EDI through TriZetto Provider Solutions, **register or log in to TriZetto**. **Paper claims submission:** Parkland Community Health Plan ATTN: Claims P.O. Box 560327 Dallas, TX 75356 **Phone:** 1-888-672-2277 **Online: PCHP Provider Portal**
Provider Complaints	**Phone:** 1-888-672-2277 **Online: PCHP Provider Portal**
Medical Necessity Member Appeals	Member medical appeals can be initiated by the member or the provider on behalf of the member with the member's signed consent (signed consent is not required for CHIP members). An appeal request must be submitted within 60 calendar days from the date of an adverse determination. Be sure to include medical charts or other supporting information. **Mail:** Parkland Community Health Plan ATTN: Complaints and Appeals P.O. Box 560347 Dallas, TX 75356 **Fax:** 1-844-310-1823 **Email: PCHPComplaintsandAppeals@phhs.org**

Provider Claim Appeals	A provider has 120 days from the date of an Explanation of Payment (EOP) to file a payment dispute. **Mail:** Parkland Community Health Plan ATTN: Complaints and Appeals P.O. Box 560347 Dallas, TX 75356 **Online:** PCHP Provider Portal
Credentialing	**Phone:** 1-888-672-2277 **Email:** PCHP.Credentialing@phhs.org
Fraud, Waste, & Abuse Hotline	1-800-351-0093
Hearing-Impaired Services	1-800-735-2989 (TTY: 7-1-1)
Notification / Prior Authorizations	**Phone:** 1-888-672-2277 **Online:** PCHP Provider Portal **Fax:** 214-266-2085 or 1-844-303-1382 Data required for notification/prior authorization includes: • Member ID number • Legible name of referring provider and NPI • Legible name of individual referred to provider and NPI • Number of visits/services • Date(s) of service • Diagnosis • CPT/HCPCS code • Copy of physician's order for services by ancillary providers
Electronic Data Interchange	**Payer ID # 66917** To submit EDI through TriZetto Provider Solutions, register or log in to TriZetto.
PCHP Website	On our website at Provider.ParklandHealthPlan.com, you can find: • Preferred drug list • List of drugs requiring prior authorization • Provider manuals • Provider directories • Provider newsletters • Prior authorization list • Credentialing and recredentialing • Electronic remittance advice and electronic funds transfer • Electronic Visit Verification • Case Management support • Quality Improvement • Texas Health Steps • Cultural Competency • Children of Migrant Farm Workers

	• Health plan and industry updates • Clinical Practice Guidelines • Forms and resources • Available provider trainings
PCHP Provider Portal (for claim filing, claim status inquiries, member eligibility and benefits information, and prior authorization)	**Click this link**: **PCHP Provider Portal** **Or navigate to**: **Provider.ParklandHealthPlan.com** and click on the "Provider Login" button
Dental Services	**DentaQuest Medicaid:** 1-800-516-0165 **DentaQuest CHIP:** 1-800-508-6775 **MCNA Dental:** 1-800-494-6262 **UnitedHealthcare:** 1-800-822-5353
Vision Services (Avesis)	**Members:** 1-866-678-7113 **Providers:** 1-866-563-3591
NEMT (non-emergent transportation other than ambulance) Services (STAR only)	1-833-931-3844
Pharmacy Services (Navitus)	1-877-908-6023 **navitus.com**
Enrollment/Disenrollment Medicaid and CHIP	1-800-964-2777 (Medicaid and CHIP)
Medicaid / CHIP Helpline	1-800-964-2777 or 2-1-1
Texas Health Steps	1-877-847-8377

Provider Roles

Role of the Primary Care Provider (PCP) or Medical Home

The PCP serves as a "medical home" and is responsible for all provisions of primary care, including preventive health services, in accordance with the STAR/CHIP programs. The PCP is responsible for coordinating care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. In addition, the PCP is responsible for reporting abuse or neglect, sending PCHP updated provider information, and maintaining and retaining all necessary documentation and records.

Role of the Specialty Care Provider

The role of the specialty care provider (specialist) is to meet the medical specialty needs of STAR and CHIP members and provide all medically necessary covered services.

Network referrals from the PCP are not required for in-network specialists. The specialist, including behavioral health providers, coordinates care with the member's PCP and is responsible for obtaining prior authorization for services that require authorization prior to

rendering the service. Services requested or provided must be within the member's plan as a covered benefit. Our service coordinators are available to assist specialty providers with the management of catastrophic, chronic, or problem cases.

Role of the CHIP Perinatal Provider

The role of the CHIP Perinatal provider, usually an OB/GYN, is to meet the prenatal, delivery, and postpartum needs of the CHIP Perinate unborn child by providing all medically necessary covered services. The role of the CHIP Perinatal provider caring for the CHIP Perinate newborn has the same functions as primary care and specialty providers listed above.

Role of Pharmacy

All members have access to pharmacy services. PCHP has an arrangement with Navitus Health Solutions to administer pharmacy benefits for PCHP's CHIP and STAR members. Navitus is contracted with pharmacies that serve CHIP and STAR managed care members. PCHP and Navitus are required by state law to adhere to the Medicaid Preferred Drug List (PDL).

CHIP and STAR formularies are still managed by HHSC and are available on the Vendor Drug Program (VDP) website at **txvendordrug.com**. PCHP and Navitus network providers can also access the formulary and PDL at this site.

Role of Main Dental Home

Dental plan members may choose their main dental homes. A dental plan will assign each member to a main dental home if he/she does not choose one. Whether chosen or assigned, each member who is 6 months of age 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

Members are limited to the use of PCHP-contracted providers except for emergency care. However, exceptions may be made in cases where the member's medical or behavioral health condition could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. All elective (non-urgent) out-of-network referrals require prior authorization and are reviewed and approved by the PCHP medical director or designee. Referral is not required for in-network specialty care physicians.

Providers with the following specialties can apply for enrollment with us as PCPs:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology (OB/GYN)
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs) and similar community clinics
- Indian Health Care Providers (IHCP) for American Indian members

Providers must be enrolled with Texas Medicaid in one of the specialties listed above to serve as a PCP.

Chapter 2: **STAR Covered Services**

Texas Health Steps Services

Texas Health Steps (THSteps) is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. THSteps provides regular medical and dental checkups and case management services to babies, children, teens, and young adults. THSteps must be offered for all new members age 20 and younger who are due, soon due, or overdue for checkups or case management services. These services must be performed no later than:

- 14 days from the date of enrollment for newborns.
- 90 days from the date of enrollment for all other eligible child members.

The THSteps annual medical checkup for an existing member 3 years of age (36 months) and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the Texas Medicaid Provider Procedures Manual (TMPPM), based on the member's birth date.

PCHP members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit. We encourage physician contact within 24 hours for newborns. Our members are eligible to receive these services from birth through age 20. The program provides the following:

- Age-appropriate immunizations
- Appropriate laboratory tests
- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Health education
- Physical and mental development assessment

Resources

Resource	Link
Texas Medicaid Provider Procedures Manual (TMPPM)	Texas Medicaid Provider Procedures Manual | TMHP
Texas Health Steps website	www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/texas-health-steps
Texas Health Steps Provider Relations contact website	www.hhs.texas.gov/providers/health-services-providers/texas-health-steps
Texas Health Steps Training Website	www.txhealthsteps.com

Information includes the following:

- Periodicity schedule
- State and federally mandated elements of the THSteps exam
- State provider enrollment requirements and TPI requirements
- Dental varnish provider participation requirements
- Advisory Committee on Immunization Practice (ACIP) immunization schedule
- Vaccines for Children (VFC) program description
- ImmTrac (immunization registry)
- Submission of all laboratory specimens (collected as a required component of a THSteps checkup to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis)
- Referrals
- Comprehensive care program services, including private duty nursing, prescribed pediatric extended care centers and therapies

THSteps medical providers (participating and non-participating) may perform THSteps medical checkups on any PCHP member, regardless of panel assignment. Claims for these services should be submitted to us. Please fax or mail a copy of the THSteps record to the member's PCP. THSteps network providers are reimbursed according to their contracts with us. Non-participating providers will be paid in accordance with the state's out-of-network rules.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the member's medical condition, or the authorized hours are not commensurate with the member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Texas Health Steps and newly enrolled STAR members age 20 and younger

Newly enrolled STAR members age 20 and younger are informed through welcome calls and new member information of the need to receive a medical checkup within 90 days of enrollment. Automated call scripts are designed to identify problems encountered by the member with enrollment and initiating services. Based on the answers given by the member during the call, a Member Advocate will perform a follow-up call if needed to resolve any issues.

For newborns, the medical checkup should in no case occur later than 14 days from the date of enrollment. Throughout the year, we remind members of the need to obtain their periodic THSteps medical checkups, diagnoses and treatment for routine and acute care through:

- The member handbook
- Telephone calls
- Welcome information in the new member packet
- Member newsletters
- Preventive health reminders

The THSteps annual medical checkup for an existing member aged 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date in the TMPPM, based on the member's birth date. If a member misses a THSteps medical checkup appointment, the provider and office staff must:

- Document the missed appointment and efforts to contact the member in the member's medical record.
- Contact the member to reschedule the appointment.

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 THSteps periodicity schedule for children as described in the Texas **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 tuberculosis, 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 **THSteps periodicity schedule** based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening

- A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The THSteps Tuberculosis Questionnaire is required annually beginning at 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, front 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 front 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 **www.dshs.texas.gov/immunize/tvfc**.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia:
   - Newborn screening: Send all THSteps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn members and the member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up THSteps medical checkup.
   - Anemia screening at 12 months.
   - Dyslipidemia screening at 9 to 12 years of age and again 18-20 years of age
   - HIV screening at 16-18 years of age

- Risk-based screenings include dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis, and gonorrhea/chlamydia.

5. **Health education** (including anticipatory guidance) is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers, and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents, and disease.
6. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.
   - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

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

Children of Migrant Farmworkers

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

Performing a make-up exam for a late THSteps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Telemedicine, Telehealth, and Telemonitoring Access

We encourage our network providers to offer telemedicine, telehealth, and telemonitoring capabilities to our members. Information will be included in our provider directories as to which providers have these services available.

School-based telemedicine medical services are a covered service for members in a primary or secondary school-based setting. We will reimburse an eligible distant site physician providing treatment even if the physician is not the patient's PCP or is an out-of-network physician. Prior authorization is not required for school-based telemedicine medical services. To be

eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code §531.0217 (c-4).

The school-based telemedicine medical services in this section are separate and distinct from School Health and Related Services (SHARS) services. We will only reimburse school-based telemedicine medical services that are not considered SHARS.

Ambulance Transportation Services

Emergent ambulance transportation service is a benefit when the member has an emergency medical condition. See the emergency services section for the definition of an emergency medical condition.

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the member.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

Non-Emergent Ambulance Transportation

Non-emergency ambulance transport is a benefit when provided for a member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the member's home after discharge from a hospital if the member has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated). In this circumstance, contraindicated means the member cannot be transported by any other means from the origin to the destination without endangering the individual's health.

A physician, nursing facility, health care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed, submitted via the **Provider Portal**, or called in via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by non-emergent ambulance transportation. The ambulance provider may not submit an authorization request.

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Some requests for non-emergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day.

Non-Emergency Medical Transportation Services (NEMT) (STAR Members only)

Access2Care at 1-833-931-3844

What are NEMT Services?

NEMT services provide transportation to covered health care services for Medicaid 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. NEMT services do NOT include ambulance trips.

What services are part of NEMT services?

- 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 service 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 healthcare service. The ITP can be the member, the member's family member, friend, or neighbor.
- Members age 20 or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members age 20 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.

If you have a member needing assistance while traveling to and from his or her appointment with you, Access2Care 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, please refer him or her to PCHP at 1-833-931-3844 for more information.

Dental Services

PCHP STAR members aged 20 and younger are covered for dental services through their core Medicaid benefits. Members select a dental maintenance organization through HHSC's enrollment broker to provide these services.

Medicaid Emergency Dental Services

Emergency dental services are also delivered through the PCHP for STAR members and can be provided to Medicaid members in a hospital, free-standing emergency room, or an ambulatory surgical center setting. PCHP 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 removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for correction of craniofacial anomalies and drugs.

Medicaid Non-Emergency Dental Services

PCHP is **not responsible** for paying for routine dental services provided to Medicaid members. These services are paid through Dental Managed Care Organizations.

PCHP is **responsible** for paying for treatment and devices for craniofacial anomalies, and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a THSteps medical checkup for Members age 6 through 35 months.

Medical providers for THSteps must complete training and become certified to provide the intermediate oral evaluation and fluoride varnish application before providing these services. Federally qualified health center (FQHC) providers will be certified at the facility level. Training for certification is available as a free continuing education course on the THSteps website at **txhealthsteps.com**.

- The 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 THSteps providers on the same day as the THSteps medical checkup (99381, 99382, 99391, or 99392).
- OEFV must be billed concurrently with a THSteps medical checkup utilizing CPT code 99429 with U5 modifier and diagnosis code Z00.121 or Z00.129.
- Documentation must include all components of the OEFV.

- THSteps providers must assist members with establishing a Main Dental Home and document the member's Main Dental Home choice in the member's file.
- A maximum of six services may be billed per member lifetime by any provider. There is no additional reimbursement for OEFV services for FQHCs.

For more information, see **www.hhs.texas.gov/providers/health-services-providers/texas-healthsteps/medical-providers/oral-evaluation-fluoride-varnish-medical-home**.

CHIP Emergency Dental Services

PCHP is responsible for emergency dental services provided to CHIP members and CHIP Perinate Newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

CHIP Non-Emergency Dental Services

PCHP is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinatal members. These services are paid through dental managed care organizations. PCHP is **responsible** for paying for treatment and devices for craniofacial anomalies.

PCHP will provide coverage for fluoride varnish for CHIP members in accordance with American Academy of Pediatrics (AAP) guidelines.

Vision Services

Coverage for STAR members may be obtained by calling Avesis at 1-866-678-7113 (members) or 1-866-563-3591 (providers). Services are available for member self-referral to a network vision provider for all vision benefits.

Vision Benefits by Member Category

Member Category	Benefits	Contact
STAR members age 20 and younger	One eye exam every 12 months. Medically necessary frames and lenses or contact lenses once every 24 months.	Coverage may be obtained by calling Avesis at 1-866-678-7113 (members) or 1-866-563-3591 (providers).
STAR adult members age 21 and older	One eye exam and medically necessary frames and lenses or contact lenses once every 24 months.	Coverage may be obtained by calling Avesis at 1-866-678-7113 (members) or 1-866-563-3591 (providers).

STAR Managed Care Covered Services

PCHP will provide STAR members a benefit package that includes fee-for-service (FFS) services currently covered under the Medicaid program. Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for a more inclusive listing of limitations and exclusions. Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through the provider website, mailings, faxes, emails, newsletters, and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

Acute care covered services (core Medicaid services covered by PCHP):

Medicaid covered acute care services include but are not limited to medically necessary:

- Ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral Health services including*:
    - Inpatient mental health services for adults and children
    - Outpatient mental health services for adults and children
- Psychiatry services or mental health rehabilitative services
- Counseling services for adults (age 21 and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy
    - Residential substance use disorder treatment services including detoxification services
- Birthing services provided by a physician or certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Home health care services
- Hospital services (inpatient and outpatient)

- Laboratory services
- Mastectomy, breast reconstruction, and external breast prosthesis-related follow-up procedures including:
    - Inpatient services, outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate, physician and professional services provided in an office, inpatient or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of lymphedemas
        - Prophylactic mastectomy to prevent the development of breast cancer
    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance
- Medical checkups and Comprehensive Care Program (CCP) services for children (birth through age 20) through the THSteps program
- Mental health targeted case management
- Nonemergency medical transportation services
- Oral evaluation and fluoride varnish in the medical home in conjunction with THSteps medical checkup for children 6 months through 35 months of age
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist, or physician assistant in a licensed birthing center
- Prescription drugs, medications, and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Primary care services
- Preventive services including annual adult well checks (age 21 and older)
- Radiology, imaging, and X-rays
- Specialty physician services
- Telehealth
- Telemonitoring
- Therapies (physical, occupational, and speech)
- Transplantation of organs and tissues

- Vision services including optometry and glasses (contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses)

*Behavioral health services are not subject to quantitative treatment limitations that apply under traditional fee-for-service Medicaid. These services may be subject to non-quantitative treatment limitations that comply with Mental Health Parity and Addiction Equity Act of 2008.

Medicaid Program Exclusions

The following services are not covered by PCHP or traditional FFS Medicaid:

- All services not medically necessary
- All services not provided, approved, or arranged by a network provider or preauthorized by a nonparticipating provider with the exception of emergency, THSteps, and family planning services
- Cosmetic surgery, except when medically necessary
- Experimental organ transplants
- Infertility treatments and drugs
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to the care of the patient
- Services provided in federally operated facilities
- Other services listed in the TMPPM as noncovered benefits (located at **tmhp.com**)

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage in delivery	Coverage for newborn	Breast pump coverage and billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.

CHIP Perinate, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinate, with income above 198% FPL	CHIP Perinate	CHIP Perinate	CHIP covers breast pumps and supplies when medically necessary for CHIP Perinate newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinate ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

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

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

Coordination With Non-Medicaid Managed Care Covered Services

In addition to MCO coverage, STAR members are eligible for the services described below. PCHP and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM):

- THSteps dental (including orthodontia)
- THSteps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)

- For STAR, THSteps personal care services for members birth through age 20
- For STAR, Community First Choice (CFC) services
- For members who are prospectively enrolled in STAR from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are noncapitated services, except for a stay in a chemical dependency treatment facility for STAR members

Family Planning Services

Family planning services are a covered benefit of the Medicaid program. We cover family planning services, including medically necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program (VDP). We reimburse out-of-network family planning providers in accordance with HHSC administrative rules. Except as otherwise noted, no prior authorization is required for family planning services.

STAR members must be allowed:

- The freedom to choose medically appropriate contraceptive methods.
- The freedom to accept or reject services without coercion.
- To receive services without regard to age, marital status, sex, race or ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- To self-refer for family planning services to any Texas Health and Human Services-approved family planning provider listed on the web at **healthytexaswomen.org/family-planning-program**.

Only members receiving family planning services, not their parents, spouse, or any other individual, may consent to the provision of family planning services. Providers cannot require parental consent for minors to receive family planning services and must keep family planning use confidential in accordance with applicable privacy laws. However, counseling should be offered to adolescents to encourage them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.

CHIP and CHIP Perinate Covered Services

CHIP Covered Services

PCHP provides a CHIP benefit package that includes services covered by the CHIP and CHIP Perinate programs offered by the Texas Health and Human Services Commission. All covered services must meet the CHIP definition of "Medically Necessary Covered Services."

CHIP Perinate Covered Services

CHIP Perinatal services must meet the definition of medically necessary covered services to be covered. There is no lifetime maximum on benefits; however, the 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

Copays do not apply to CHIP Perinatal members. Copays, cost sharing, and enrollment fees still apply to other children in the family enrolled in the CHIP program. CHIP Perinate newborns are eligible for 12 months of continuous coverage beginning with the month of enrollment as a CHIP Perinatal member. A CHIP Perinate will continue to receive coverage through the CHIP program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan. CHIP Perinate Newborns have the same benefits as CHIP members, as shown in the table below.

A CHIP Perinate (unborn child) member who lives in a family with an income at or below the Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage effective on the date of birth after the birth is reported to HHSC's enrollment broker.

Note that CHIP Perinate members in families with incomes at or below the Medicaid eligibility threshold are not covered for facility charges related to labor and delivery. These members should apply for Medicaid coverage to cover these services. HHSC has structured CHIP Perinatal with the expectation that members in this income bracket will be eligible for emergency Medicaid to cover these facility charges. The emergency Medicaid coverage would include both labor and delivery charges and the newborn's facility charges until discharge. Professional services are covered under the CHIP program for this population.

A CHIP Perinate mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under the Medicaid eligibility threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.

CHIP and CHIP Perinate Newborn	Limitations
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	• Requires authorization for non-emergency care and care following

• Hospital-provided physician or provider services
• Semi-private room and board (or private if medically necessary as certified by attending)
• General nursing care
• Special duty nursing when medically necessary
• ICU and services
• Patient meals and special diets
• Operating, recovery, and other treatment rooms
• Anesthesia and administration (facility technical component)
• Surgical dressings, trays, casts, splints
• Drugs, medications and biologicals
• Blood or blood products that are not provided free of charge to the patient and their administration
• X-rays, imaging, and other radiological tests (facility technical component)
• Laboratory and pathology services (facility technical component)
• Machine diagnostic tests (EEGs, EKGs, etc.)
• Oxygen services and inhalation therapy
• Radiation and chemotherapy
• Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care
• In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.
• Hospital, physician, and related medical services, such as anesthesia, associated with dental care.
• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero); inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  ○ dilation and curettage (D&C) procedures.
  ○ appropriate provider administered medications.
  ○ ultrasounds.
  ○ histological examination of tissue samples.
	stabilization of an emergency condition.
	• May require authorization for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  o cleft lip and/or palate.
  o severe traumatic, skeletal, and/or congenital craniofacial deviations.
  o severe facial asymmetry secondary to skeletal defects, congenital syndromal condition, and/or tumor growth or its treatment.
• Surgical implants
• Other artificial aids including surgical implants
• Inpatient services for a mastectomy and breast reconstruction include:
  o all stages of reconstruction on the affected breast.
  o surgery and reconstruction on the other breast to produce symmetrical appearance.
  o treatment of physical complications from the mastectomy and treatment of lymphedemas.
• Implantable devices are covered under Inpatient and Outpatient services and do not count toward the DME 12-month period limit.	

Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and physician prescription • 60 days per 12-month period limit
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting:	• May require prior authorization and physician prescription

• X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free of charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: o dilation and curettage (D&C) procedures. o appropriate provider administered medications. Ultrasounds. o histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: o cleft lip and/or palate. o severe traumatic, skeletal and/or congenital craniofacial deviations. o severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical implants	

• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
  o all stages of reconstruction on the affected breast.
  o surgery and reconstruction on the other breast to produce symmetrical appearance.
  o treatment of physical complications from the mastectomy and treatment of lymphedemas.
Implantable devices are covered under Inpatient and Outpatient services and do not count toward the DME 12-month period limit.	

Physician/Physician Extender Professional Services Services include but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, inpatient and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care • Administration of anesthesia by physician (other than surgeon) or CRNA • Second surgical opinions • Same-day surgery performed in a hospital without an overnight stay • Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components)	• May require authorization for specialty services

• Physician and professional services for a mastectomy and breast reconstruction include:
  o all stages of reconstruction on the affected breast;
  o surgery and reconstruction on the other breast to produce symmetrical appearance; and
  o treatment of physical complications from the mastectomy and treatment of lymphedemas.
• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.
• Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  o dilation and curettage (D&C) procedures; appropriate provider administered medications; ultrasounds; and histological examination of tissue samples.
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  o cleft lip and/or palate.
  o severe traumatic, skeletal and/or congenital craniofacial deviations.
  o severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment.	

Birthing Center Services Covers birthing services provided by a licensed birthing center.	• Limited to facility services (e.g., labor and delivery) • Applies only to CHIP members

Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.	• **CHIP Members:** Covers prenatal services rendered in a licensed birthing center. • **CHIP Perinate members:** Covers services rendered to a newborn immediately following delivery.
Durable Medical Equipment (DME), Prosthetic Devices, and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under Inpatient and Outpatient services and do not count toward the DME 12-month period limit. Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	• May require prior authorization and physician prescription • $20,000 per 12-month period limit for DME, prosthetic devices, and disposable medical supplies (implantable devices, diabetic supplies, and equipment are not counted against this cap).
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. Speech, physical, and occupational therapies.	• Requires prior authorization and physician prescription. • Services are not intended to replace the child's caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.

Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • When inpatient psychiatric services are ordered 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapter D; or 2) as a condition of probation. The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the member is considered incarcerated, as defined by UMCM Section 16.1.15.2.	• Requires prior authorization for non-emergency services • Does not require PCP referral

CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

CHIP Exclusions from Covered Services

These services are excluded from coverage:

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (in other words, cannot be prescribed for family planning)
- Personal comfort items, including personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community; this exclusion is an adverse determination and is eligible for review by an Independent Review Organization
- Treatment or evaluations required by third parties including but not limited to those for schools, employment, flight clearance, camps, insurance, or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapter

573, Subchapters B and C, Chapter 574, Subchapter D, or Chapter 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D

- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices, including an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the health plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan, except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse, or loss when confirmed by the member or the vendor
- Corrective orthopedic shoes
- Over-the-counter medications
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care that assists a child with daily living activities, such as assisting with walking, getting in and out of bed, bathing, dressing, feeding, toileting, preparing a special diet, and supervising medication that is usually self-administered or provided

by a parent; this care does not require the continuing attention of trained medical or paramedical personnel; exclusion does not apply to hospice services

- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services when ordered by a physician/PCP
- Donor nonmedical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP Perinatal Covered Services

CHIP Perinate newborns have the same benefits as CHIP members as outlined in the CHIP Covered Services section of this manual. Covered services for CHIP Perinate unborns (mother) are outlined in the following table.

Covered Benefit	CHIP and CHIP Perinate Newborn Member	CHIP Perinate Members (unborn child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: • Operating, recovery, and other treatment rooms

	• Drugs, medications and biologicals • Blood or blood products that are not provided free-of charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital or ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: o all stages of reconstruction on the affected breast; o surgery and reconstruction on the other breast to produce symmetrical appearance; and o treatment of physical complications from the	• Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C procedures; • appropriate provider administered medications; • ultrasounds • histological examination of tissue samples

	mastectomy and treatment of lymphedemas. • Implantable devices are covered under inpatient and outpatient services and do not count toward the DME • 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: o cleft lip and/or palate o severe traumatic skeletal and/or congenital craniofacial deviations o severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment	
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) And Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically

	• Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital or ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: o all stages of reconstruction on the affected breast; o surgery and reconstruction on the other breast to produce symmetrical appearance; and o treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME • 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical	necessary prescription and injection drugs. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: o dilation and curettage (D&C) procedures; o appropriate provider administered medications; o ultrasounds o histological examination of tissue samples o Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. o Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation, or miscarriage or non-viable pregnancy. o Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. o Laboratory tests are limited to: nonstress testing, contraction, stress

	intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip and/or palate; or ○ severe traumatic skeletal and/or congenital craniofacial deviations; or ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment	testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. ○ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
Physician/ Physician Extender	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well child exams	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and

Professional Services	and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient, and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care o Administration of anesthesia by physician (other than surgeon) or CRNA o Second surgical opinions o Same-day surgery performed in a hospital without an overnight stay o Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician performed technical and interpretive components) • Physician and professional services for mastectomy and breast reconstruction include: o all stages of reconstruction on the affected breast; o surgery and reconstruction on the other breast to produce symmetrical appearance; and	postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient, and outpatient services • Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation • Medically necessary medications, biologicals and materials administered in physician's office • Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth o Administration of anesthesia by physician (other than surgeon) or CRNA o Invasive diagnostic procedures directly related to the labor with delivery of the unborn child o Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic, pregnancy or a fetus that expired in utero) • Hospital-based physician services (including physician performed technical and interpretive components) • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation or gestational age confirmation

	○ treatment of physical complications from the mastectomy and treatment of lymphedemas • In-network and out-of network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip and/or palate; or ○ severe traumatic skeletal and/or congenital craniofacial deviations; or ○ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment	• Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis and FIUT • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: ○ dilation and curettage (D&C) procedures; ○ appropriate provider administered medications; ○ ultrasounds, and ○ histological examination of tissue samples
Birthing Center Services	Covers services rendered to a newborn immediately following delivery.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Prenatal Care and Pre-Pregnancy	Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system and	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include:

Family Services and Supplies	limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre pregnancy family reproductive services and supplies or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	• One visit every 4 weeks for the first 28 weeks or pregnancy; • One visit every 2-3 weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • interim history (problems, marital status, fetal status); • physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and • laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Services Rendered by a Certified Nurse Midwife or	Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are

Physician in a Licensed Birthing Center		limited to an initial visit and subsequent prenatal (antepartum) care visits that include: (1) One visit every 4 weeks for the first 28 weeks or pregnancy; (2) one visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to: Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • interim history (problems, marital status, fetal status); • physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Drug benefits	Services include, but are not limited to, the following:	Services include, but are not limited to, the following:

	• Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting	• Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting Services must be medically necessary for the unborn child.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics dental devices • Prosthetic devices such as artificial eyes, limbs, braces and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at **txvendordrug.com** and only when they are obtained from a CHIP-enrolled pharmacy provider.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN)	Not a covered benefit.

	• Skilled nursing visits as defined for home health purposes • (may include RN or LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code relating to court ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Does not require PCP referral	Not a covered benefit.
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:	Not a covered benefit.

	• The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment • Skills training (psycho educational skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code relating to court ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • A Qualified Mental Health Provider Community Services (QMHP-CSs), is defined by and credentialed through the Texas Department of State Health Services (DSHS) Title 25 T.A.C., Part I, Chapter • 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority (LMHA) or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be	

	components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral	
Inpatient Substance Use Disorder Treatment Services	Services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral	Not a covered benefit.
Outpatient Substance Use Disorder Treatment Services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral • for chemical dependency disorders • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day	Not a covered benefit.
Rehabilitation Services	Services include but are not limited to the following: • Habilitation (the process of supplying a child with the means to reach age appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: o Physical, occupational and speech therapy o Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include but are not limited to:	Not a covered benefit.

	• Palliative care including medical and support services for those children who have six months or less to live to keep patients comfortable during the last weeks and months before death • Treatment services including treatment related to the terminal illness • Up to a maximum of 120 days with a six-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	
Emergency Services, Including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions labor and delivery. Covered services include but are not limited to the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removal of cysts	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child • Stabilization services related to the labor with delivery of the covered unborn child • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) is a covered benefit Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of

		the CHIP Perinate are not a covered benefit.
Transplants	Services include but are not limited to the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses	Not a covered benefit.
Vision benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program • Health plan defines plan approved program • May be subject to formulary requirements	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy dispensed and provider administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.

		Services must be medically necessary for the unborn child.

CHIP Perinatal — exclusions from covered services for CHIP Perinates

These services are excluded from coverage:

- Inpatient facility charges for the initial CHIP Perinate newborn admission for CHIP Perinate mothers in families with incomes at or below the Medicaid eligibility threshold (initial CHIP Perinate newborn admission refers to the hospitalization associated with the birth)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to a miscarriage, a nonviable pregnancy, and postpartum care related to the covered unborn child until birth
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (in other words, cannot be prescribed for family planning)
- Inpatient mental health services
- Outpatient mental health services
- DME or other medically related remedial devices
- Disposable medical supplies
- Home- and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance use treatment services and residential substance use treatment services
- Outpatient substance use treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the labor with delivery of the covered unborn child
- Transplant services
- Tobacco cessation programs

- Chiropractic services
- Medical transportation not directly related to labor or threatened labor, miscarriage or nonviable pregnancy, and/or delivery of the covered unborn child
- Personal comfort items, including:
- Personal care kits provided on inpatient admission
- Telephone
- Television
- Newborn infant photographs
- Meals for guests of patient
- Other articles not required for the specific treatment related to labor with delivery or postpartum care
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties, including those for schools, employment, flight clearance, camps, insurance, or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices, including an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the health plan, except for emergency care related to labor with delivery of the covered unborn child
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel

- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care that assists with the activities of daily living, such as:
    - Assisting with walking
    - Getting in and out of bed
    - Bathing
    - Dressing
    - Feeding
    - Toileting
    - Preparing special diets
    - Supervising medication that is usually self-administered or provided by a caregiver; this care does not require the continuing attention of trained medical or paramedical personnel
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services
- Donor nonmedical expenses
- Charges incurred as a donor of an organ

CHIP Perinatal exclusions from covered services for CHIP Perinate newborns

With the exception of the item below, all CHIP Perinate newborn exclusions match those of CHIP.

For CHIP Perinate newborns in families with incomes at or below the Medicaid eligibility threshold, inpatient facility charges are not a covered benefit for the initial CHIP Perinate newborn admission. Initial CHIP Perinate newborn admission means the hospitalization associated with the birth.

Coordination with non-CHIP covered services

We will coordinate with public health entities to provide essential public health care (noncapitated) services to CHIP Perinate members. Our primary role in this collaboration is to:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law.
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members.
- Educate members and providers regarding WIC services available to members.
- Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

In addition to coordinating with public health entities, we will work with other state HHS programs to provide essential public health care services. In this role, we will:

- Notify providers of the availability of vaccines through the Texas Vaccines for Children program.
- Work with HHSC and providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.
- Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community-based needs assessment.
- Report all blood lead results to the Childhood Lead Poisoning Prevention Program unless the test was performed at the DSHS state laboratory, and coordinate and follow up on suspected or confirmed cases of childhood lead exposure with local public health entities that have a child lead program or with the Childhood Lead Poisoning Prevention Program in DSHS when the local public health entity does not have a program; additionally, follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated blood levels located at dshs.texas.gov/blood-lead-surveillance-group/for-providers and coordinate with the Texas Health Steps Outreach and Informing Unit.

Breast pump coverage for CHIP Perinate members

Refer to the Breast Pump Coverage in Medicaid and CHIP section of this manual.

Referrals to health-related services — all products

PCHP will enlist the involvement of community organizations that may not provide Medicaid or CHIP covered services but are otherwise important to the health and well-being of members. We will make our best effort to establish relationships with these community organizations to make referrals. These organizations may include:

- Texas ECI Program
- Texas Department of Mental Health and Mental Retardation (MHMR)
- Texas Department of Health Title V Program
- Local school district special education
- Other state and local agencies and programs with jurisdiction over children's services including food stamps and the Women, Infants, and Children program
- Texas information and referral network
- Texas Commission for the Blind
- Child-service civic and religious organizations, and consumer and advocacy groups, such as United Cerebral Palsy, that also work on behalf of the CSHCN population; service coordinators can offer assistance with coordination of care for these members.

Value-added services—all products

We cover extra health care benefits for our members. These extra benefits are also called value-added services. You can find a list of these benefits in our member handbooks or on our website at **ParklandHealthPlan.com**.

Chapter 3: **Pharmacy Services**

Overview

PCHP has an arrangement with Navitus Health Solutions to administer pharmacy benefits for PCHP's CHIP and STAR members. Members may obtain their medications at any network pharmacy unless HHSC has placed the member in the Office of Inspector General (OIG) Lock-In Program.

For questions related to the formulary, preferred drug list, billing, prescription overrides, prior authorizations, quantity limits, or formulary exceptions, call Navitus at 1-877-908-6023 to speak with the Prior Authorization department between 8 am and 5pm CST, Monday through Friday, or access the Navitus website at **www.navitus.com**.

Pharmacy providers are responsible for but not limited to the following:

- Filling prescriptions in accordance with the benefit design
- Adhering to the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all medication for which they are eligible
- Coordinating benefits when a member also receives other insurance benefits
- Providing a 72-hour emergency supply of prescribed medication any time a prior authorization is not available, if the prescribing provider cannot be reached or is unable to request a prior authorization and a prescription must be filled without delay for a medical condition
    - **Note:** Certain drugs, such as hepatitis C drugs, are excluded from the 72-hour emergency supply rule

Prescription Limits

All prescriptions are limited to a maximum 34-day supply per fill except for CHIP members, and all prescriptions for non-controlled substances are valid only for 11 refills or 12 months from the date the prescription was written, whichever is less.

CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

Office of Inspector General (OIG) Lock-In Program

The HHSC OIG Lock-In Program restricts, or locks in, a Medicaid member to a designated pharmacy if it finds that the member used drugs covered by Medicaid at a frequency or in an amount that is duplicative, excessive, contraindicated, or conflicting, or that the member's actions indicate abuse, misuse, or fraud.

Some circumstances allow a member to be approved to receive medications from a pharmacy other than the lock-in pharmacy. A one-time pharmacy override occurs when PCHP approves a member's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. To request a pharmacy override, the member should contact PCHP Member Services at 1-888-672-2277.

Allowable circumstances for a one-time pharmacy override approval:

- The member moved out of the geographical area (more than 15 miles from the lock-in pharmacy)
- The lock-in pharmacy does not have the prescribed medication and the medication will not be available for more than 2-3 days
- The lock-in pharmacy is closed for the day and the member needs the medication urgently

Covered Drugs

The PCHP pharmacy program utilizes the Texas Medicaid/CHIP VDP formulary and Preferred Drug List (PDL). The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories, vitamin and mineral products, and other select non-drug products reviewed and approved by the Drug Utilization Review Board. Please refer to the VDP formulary and PDL at **www.txvendordrug.com**

Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the formulary and are covered if prescribed by a licensed prescriber. OTC medications are generally not covered for CHIP members; however, an exception exists for insulin. To prescribe medications that do not appear on the PDL or those that require clinical prior authorization, call Navitus at 1-877-908-6023 for prior authorization.

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered.

Vitamins and minerals for members under age 21 are reimbursable.

We may limit coverage of drugs listed in the TDCI per the VDP. Procedures used to limit utilization may include prior approval, cost containment caps or adherence to specific dosage limitations according to FDA-approved product labeling. Limitations placed on the specific drugs are indicated in the TDCI.

PCHP reimburses for medication-assisted opioid or substance use disorder treatment, which includes the use of methadone, buprenorphine, oral buprenorphine/naloxone, or naltrexone, in accordance with state requirements and the PCHP fee schedule.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the PDL
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the VDP formulary
- PDL-listed legend contraceptives
    - **Exception:** Injectable contraceptives may be dispensed up to a 90-day supply

Specialty Drug Program

PCHP covers most specialty drugs under the pharmacy benefit. These drugs may be obtained at any network pharmacy that handles these types of drugs. Some drugs may require a prior authorization.

The conditions typically treated with specialty injectable drugs are growth hormone deficiency, cancer, multiple sclerosis, hemophilia, rheumatoid arthritis, hepatitis, and cystic fibrosis.

Excluded Drugs

The following drugs are excluded from the pharmacy benefit:

- Any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program, in accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8
- Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8, such as:

    - Weight control products (except orlistat, which requires prior authorization)
    - Drugs used for cosmetic reasons or hair growth
    - Experimental or investigational drugs
    - Drugs used for experimental or investigational indication
    - Infertility medications
    - Erectile dysfunction drugs to treat impotence
- Non-legend drugs other than those specifically listed as covered

Prior Authorization

Navitus processes pharmacy prior authorizations (PA) for PCHP. The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by the Health and Human Services Commission (HHSC). Information regarding the formulary and the specific prior authorization criteria can be found at **www.txvendordrug.com**, **www.epocrates.com**, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online at **ParklandHealthPlan.com** under the Providers section or have them faxed by Customer Care to the prescriber's office. Prescribers will need to provide their NPI and state to access the portal. Completed forms can be faxed 24/7 to Navitus at 920-735-5312.

Prescribers can also call Navitus Customer Care at 1-877-908-6023 and speak with the PA department Monday through Friday, from 8 am and 5 pm Central time, to submit a PA request over the phone. After hours, providers have the option to leave a voicemail. Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

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 PA either because they are nonpreferred 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 (VDP) 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, it is permissible to

indicate that the emergency prescription is a three-day supply and enter the full quantity dispensed.

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

- "8" in "Prior Authorization Type Code" (Field 461 EU)
- "8Ø1" in "Prior Authorization Number Submitted" (Field 462 EV)
- "3" in "Days' Supply" (Field 4Ø5 D5, in the Claim segment of the billing transaction)
- The quantity submitted in "Quantity Dispensed" (Field 442 E7) should not exceed the quantity necessary for a three-day supply, according to the directions for administration given by the prescriber

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

Durable Medical Equipment/Other Products Normally Found in a Pharmacy

PCHP reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), PCHP also reimburses for items typically covered under the THSteps program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), pharmacies must be enrolled as DME providers and submit claims for most DME to PCHP as a medical benefit.

For all other DME, the provider must be enrolled in the PCHP network by contacting Network Development at **PCHP.ContractingDepartment@phhs.org**.

Some durable medical supplies included in the VDP list of limited home health supplies can be submitted to Navitus as a pharmacy benefit.

To be reimbursed for DME under the pharmacy benefit, a pharmacy must first enroll in the Navitus network by contacting Navitus at 1-608-298-5775 or via email at **providerrelations@navitus.com**.

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

Chapter 4: **Provider Responsibilities**

Provider Rights and Responsibilities

Providers' Bill of Rights

Each health care provider who contracts with HHSC or subcontracts with PCHP to furnish services to members will be assured of the following rights:

- To not be prohibited (when acting within the lawful scope of practice) from advising or advocating on behalf of a member who is his or her patient for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    - Any information the member needs in order to decide among all relevant treatment options
    - The risks, benefits, and consequences of treatment or non-treatment
    - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the complaint, appeal, external medical review, and state fair hearing procedures
- To have access to PCHP policies and procedures covering the authorization of services
- To be notified of any decision by PCHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of a Medicaid member, the denial of coverage of or payment for medical assistance
- To be assured PCHP provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law solely on the basis of that license or certification

Network Provider General Responsibilities

Each health care provider contracted with PCHP has the following general responsibilities:

- The Primary Care Provider (Medical Home) is responsible for serving PCHP STAR, CHIP, and CHIP Perinate members. Provide PCHP members with a professionally recognized level of care and efficacy consistent with community standards, compliant with PCHP clinical and nonclinical guidelines and within the practice of your professional license.
- Ensure a member's right to select and have access to, without a primary care provider (PCP) referral, a network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery
- Ensure members understand the right to obtain medication from any network pharmacy
- Although a referral is not required, any referrals that are given to specialists or other health-related services must be documented. The coordination of referrals and services will be provided between the PCP and the specialist.
- Ensure that the arrangement of referrals for care and service are within the PCHP network
- The provider must submit justification, in the form of a prior authorization, to PCHP regarding out-of-network referrals, including partners not contracted with the health plan
- Treat all PCHP members in a fair and nondiscriminatory manner and with respect and consideration
- While enrolled with PCHP, members with disabilities, special health care needs, and or chronic or complex conditions have the right to designate a specialist as their PCP as long as the specialist agrees
- Verify member eligibility and obtain prior authorization for services as required by PCHP
- Support members' right to designate OB/GYNs as PCPs and specialists as PCPs (for eligible members with chronic conditions)
- Facilitate inpatient and ambulatory care services at in-network facilities
- Provide 24/7 telephone access to medical professionals for urgent/emergency needs
- Notify PCHP and the HHSC administrative services contractor of practice changes (physical or remit address, tax ID, group affiliation, or any other demographic change)
- Participate in PCHP's Quality Improvement Program initiatives
- Maintain a facility that promotes patient safety
- Participate in provider orientations and continuing education
- Arrange referrals for care and service within the PCHP network
- Help members access dental care and second opinions
- The provider must follow Community First Choice guidelines (see Appendix A).

- Maintain confidential medical records consistent with PCHP medical record guidelines (see Member Record Standards section) and ensure records are compliant with HIPAA regulations.
- Upon identification of a teen who is pregnant (STAR or CHIP), providers must contact PCHP's Service Coordination team immediately.
- Abide by the ethical principles of your profession
- Notify PCHP if you are undergoing any type of legal or regulatory investigation or if you have agreed to a written order issued by the state licensing agency for your profession
- Notify PCHP if a member has a change in eligibility status by contacting Provider Services
- Providers are required to inform members on how to report Abuse, Neglect, and Exploitation.
- Providers must ensure they have trained staff on how to recognize and report Abuse, Neglect, and Exploitation
- The Provider must provide PCHP with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).
- Notify PCHP immediately if unable to render authorized services to the full extent authorized
- Comply with PCHP policies and procedures, including those found in this provider manual and any future updates or supplements
- Abide by the terms of your PCHP Participating Provider Agreement
- Ensure members understand the right to obtain medication from any network pharmacy
- Maintain appropriate professional liability insurance that meets PCHP requirements or state-mandated requirements.

Advance Directives

We adhere to the Patient Self-Determination Act and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate. We encourage members to request education about advance directives and ask for an advance directive form from their PCP at their first appointment.

Members age 18 and older and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. PCHPwill not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

We will assist members with questions about advance directives. However, no associate of PCHP may serve as witness to an advance directive or as a member's designated agent or representative. PCHP notes the presence of advance directives in the medical records when conducting medical chart audits.

Americans with Disabilities Act Requirements

Accessibility Standards

All providers are expected to meet federal and state accessibility standards and those defined in the *Americans with Disabilities Act of 1990*. Health care services provided through PCHP must be accessible to all members. Our policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq)*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Street-level access
- Elevator or accessible ramp into facilities
- Access to lavatory that accommodates a wheelchair
- Access to examination room that accommodates a wheelchair
- Handicap parking clearly marked unless there is street-side parking

Reporting Legal or Administrative Proceedings, Changes in Address and Practice Status

Within 30 days of occurrence, a provider shall give written notice to us if he or she is named as a party in any civil, criminal, or administrative proceeding. Failure to provide such timely notice to us constitutes grounds for termination of the provider's contract with us. Providers are required to notify us of a change in address or practice status 30 days prior to the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement.

Please submit changes to **PCHPProviderInfoUpdate@phhs.org**.

Nondiscrimination for Vaccine Status

In accordance with H.B. 44, Medicaid providers are prohibited from refusing to provide health care services to any Medicaid client based solely on the client's refusal or failure to obtain a vaccine or immunization for a particular infectious or communicable disease unless excepted by Texas Government Code §531.02119.

Appointment Standards

Routine care

Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent is considered routine care.

Urgent care

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 by the member's PCP or PCP designee, within 24 hours to prevent serious deterioration of the member's condition or health.

Emergency care

Emergency care is defined as any 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
- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman

Appointment and Access Standards

We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, TDI, and the National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the three sources. Providers are required to adhere to the following access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or request, whichever occurs first.

Appointment Type	Standard
Emergency Care	Immediately upon member presentation at the service delivery site, including at non-network and out-of-network facilities.
Urgent Care	Within 24 hours.
Post-emergency room or hospital discharge (nonbehavioral health)	Within 14 calendar days
Primary routine care	Within 14 calendar days
Specialty routine care	Within 14 calendar days
Preventive health: adult 21 and older	Within 90 calendar days
Preventive health: child (new member — STAR)	Within 90 calendar days of enrollment
Preventive health: child less than 6 months old	Within 14 days
Preventive health: child age 6 months-20 years	Within 60 calendar days
Prenatal care: initial visit	Within 14 calendar days
Prenatal care: high-risk or third trimester — initial visit	Within 5 Days
Prenatal care: after initial visit	After the initial prenatal visit, subsequent appointments should be scheduled according to the developed treatment plan. Prenatal care, including routine visits and high-risk care, should be accessible within 14 days or 5 days, respectively, of the initial request
After-Hours Care	Member reaches on-call physician or medical staff within 30 minutes
Specialty Therapy evaluations	Within 21 days of submission of a signed referral
Case Management for Children and Pregnant Women services	Within 14 calendar days
Behavioral Health Appointment Type	**Standard**
Behavioral Health: non-life-threatening emergency	Within 6 hours
Behavioral Health: urgent care	Within 24 hours
Post-hospital discharge (behavioral health)	Within seven days of discharge (for missed appointments, provider must contact member within 24 hours to reschedule appointment)
Behavioral Health: routine care — initial visit	The earlier of 10 business days or 14 calendar days
Behavioral Health: routine care — follow-up visits	Within 2 weeks for behavioral health conditions (three weeks for medical)

Behavioral Health Appointment Accessibility

An Urgent Condition, including urgent specialty care and behavioral health services, must be provided within 24 hours; treatment for behavioral health services may be provided by a licensed behavioral health clinician

1. Initial outpatient behavioral health visits must be provided within 14 Days (this requirement does not apply to CHIP Perinate);
2. Initial outpatient behavioral health visits must be provided within seven days upon discharge from an inpatient psychiatric setting;

Providers may not use discriminatory practices, such as preference to other insured or private-pay patients, including separate waiting rooms, hours of operation or appointment days. We routinely monitor providers' adherence to the access to care standards.

Member Missed Appointments

PCHP members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. We require providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It's also a good time for the provider to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at 1-888-672-2277 or a health plan Member Advocate to address the situation. Our staff will contact the member and provide more extensive education and/or service coordination as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and adhering to the PCP's recommended plan of care. Providers may not bill us or our members for missed appointments.

Continuity of Care

Transition for Newly Enrolled Members

The care of newly enrolled members may not be disrupted or interrupted. This is true for care that falls within the scope of benefits. PCHP will work to provide continuity in the care of newly enrolled members whose health or behavioral health conditions have been treated by specialists or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

PCHP will honor existing service authorizations for new members in the same amount, duration and scope until the shorter of:

- 90 calendar days
- the end of the current authorization period
- the time it takes for PCHP to evaluate and assess the member and issue or deny a new authorization

In the case of a newly enrolled member who is receiving a service that did not require authorization from the prior plan, PCHP will authorize services in the same amount, duration and scope until the shorter of:

- 90 calendar days
- the time it takes for PCHP to evaluate and assess the member and issue or deny a new authorization

For members enrolling on the operational start date of an HHSC program or on the start date of a new service area, PCHP will honor existing acute-care authorizations for the earlier of 90 days or the expiration of the current authorization.

Pregnant PCHP members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their postpartum checkup within six weeks of delivery. This applies even if the providers are out-of-network. If a member wants to change her OB/GYN to one who is in the network, she will be allowed to do so if the provider to whom she wishes to transfer agrees to accept her.

For new members who have been diagnosed with a terminal illness, PCHP will approve out-of-network care by existing providers for up to nine months while enrolled with PCHP.

PCHP pays a new member's existing out-of-network providers for medically necessary covered services until the member's records, clinical information and care can be transferred to a network provider or until the member is no longer enrolled with PCHP, whichever is shorter.

Member Moves Out of Service Area

PCHP provides or pays out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which they are enrolled in PCHP.

Pre-Existing Condition Not Imposed

PCHP does not impose any pre-existing condition limitations or exclusions. PCHP does not require evidence of insurability to provide coverage to any member.

Covering Physicians

During a provider's absence or unavailability, the provider needs to arrange for coverage for their members. The provider will either:

- Make arrangements with one or more network providers to provide care for their patients
- Make arrangements with another similarly licensed and qualified provider with appropriate medical staff privileges at the same network hospital or medical group as applicable to provide care to the members in question

The covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

Locum Tenens

We allow reimbursement of locum tenens physicians in accordance with CMS guidelines, subject to benefit design, medical necessity, and authorization guidelines.

We will reimburse the member’s regular physician or medical group for all services (including emergency visits) of the locum tenens physician during the absence of the regular physician. This applies in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis. Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted rate. The locum tenens physician may not provide services to a member for more than a period of 60 continuous days.

A member’s regular physician or medical group should bill the appropriate procedure code(s) identifying the service(s) provided by the locum tenens physician. A modifier Q6 must be appended to each procedure code.

If a locum tenens physician only performs post-operative services furnished during the period covered by the global fee, these services are not identified on the claim as substitution services. Additionally, these services do not require modifier Q6.

ImmTrac

ImmTrac is the DSHS statewide immunization and tracking database system that:

- Consolidates immunization records from multiple providers into one easily accessible record

- Enables immunization providers to review patient immunization histories (providing records have been forwarded to the system) and enter information on administered vaccines
- Assists providers in dealing with complex vaccination schedule requirements and produces recall and reminder notices for vaccines that are due and overdue

Providers are required to:

- Submit immunization information to ImmTrac
- Obtain written consent to release a child's individual immunization data to ImmTrac
- Verify that the Texas birth certificate registration form includes a parental consent statement
- Providers should register with ImmTrac at **dshs.texas.gov/immunize/immtrac**

Laboratory Services (Outpatient)

All outpatient laboratory tests should be performed at a PCHP in-network reference lab or a network facility outpatient lab. The exception to this requirement is when the service being performed is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test or for THSteps.

Visit the CMS website at **CMS.hhs.gov** for a complete list of CLIA-approved tests. CLIA requires all laboratories serving Medicaid clients to maintain a certificate of registration or a certificate of waiver. Those laboratories with a certificate of waiver may only provide the following nine tests:

1. Dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen
2. Fecal occult blood
3. Ovulation tests
4. Urine pregnancy tests
5. Erythrocyte sedimentation rate, nonautomated
6. Hemoglobin-copper sulfate, nonautomated
7. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use
8. Spun microhematocrit

9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.

If a laboratory test cannot be directed to or provided by a network provider, prior authorization is required for coverage.

THSteps requires providers to use Texas Department of State Health Services (DSHS) laboratory services for specimens obtained as part of a THSteps medical checkup, including THSteps newborn screens, blood lead testing, hemoglobin electrophoresis, and total hemoglobin tests processed at the Austin Laboratory and pap smear, gonorrhea, and chlamydia screenings processed at the Women's Health Laboratories in San Antonio. Providers may submit specimens for glucose, cholesterol, HDL, lipid profile, HIV, and rapid plasma reagin (RPR) to the DSHS laboratory or to a laboratory of the provider's choice. Hematocrit may be performed at the provider's clinic if the provider needs an immediate result for anemia screening. The THSteps online provider training modules referencing specimen collection on the DSHS website and the Texas Medicaid Provider Procedures Manual, Children Services Handbook, should be referenced for the most current information and any updates.

Member's Right to Designate an OB/GYN

PCHP allows the member to pick any OB/GYN, whether that doctor is in the same network as the member's PCP or not.

Attention female members: Members have the right to pick an OB/GYN without a referral from their PCP. 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 specialty care provider (specialist) within the network

Primary Care Providers

Medical Home

The PCP is the foundation of the medical home, responsible for providing, managing, and coordinating all aspects of the member's medical care. The PCP must provide all care that is within the scope of his or her practice. Additionally, the PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.

We promote the medical home concept to all of our members. The PCP is the member's and family's initial contact point when accessing health care. The PCP has an ongoing and collaborative contractual relationship with:

- The member and family
- The health care providers within the medical home
- The extended network of consultants and specialists with whom the medical home works

The providers in the medical home are knowledgeable about the member's and family's special health related social and educational needs. The medical home providers are connected to community resources that will assist the family in meeting those needs. When a PCP refers a member for a consultation, specialty/hospital services, or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through the PCP.

Primary Care Provider Types (Network Limitations)

Physicians with the following specialties can apply for enrollment with us as PCPs:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Nurse practitioners certified as specialists in family practice or pediatrics
- FQHCs, RHCs, and similar clinics
- Obstetricians/gynecologists
- Specialist physicians who are willing to provide a medical home to selected members with special needs and conditions.

The provider must be enrolled in the Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with us for STAR.

Primary Care Provider Responsibilities

The PCP is a network physician who has the responsibility for the complete care of his or her patients, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs.

The primary care provider shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers (both in and out of network); provide coordination necessary for referrals to specialists (both in and out of network); and maintain a medical record of all services rendered including those rendered by other providers
- Make referrals for specialty care for members on a timely basis, based on the urgency of the member's medical condition, but within no later than 30 calendar days from the date the need is identified or requested
- Provide 24-hour-a-day, 7-day-a-week coverage in accordance with the after-hours coverage section of this manual; regular hours of operation should be clearly defined and communicated to members
- Be available to provide medically necessary services
- Ensure that covering physicians follow the referral/prior authorization guidelines
- Provide services ethically and legally in a culturally competent manner; meet the unique needs of members with special health care needs
- Participate in any system established by PCHP to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
- Make provisions to communicate in the language or fashion primarily used by his or her patients
- Participate and cooperate with PCHP in any reasonable internal and external quality assurance, utilization review, continuing education, and other similar programs established by PCHP
- Participate in and cooperate with the PCHP complaint procedures; we will notify the provider of any member complaint
- Not balance-bill members; however, the PCP is entitled to collect applicable copays for certain CHIP services; Medicaid members do not have an out-of-pocket expense for covered services
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan, in compliance with Occupational Safety and Health Administration standards, regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act

- Support, cooperate, and comply with the PCHP Quality Improvement Program initiatives and any related policies and procedures
- Provide quality care in a cost-effective and reasonable manner
- Inform PCHP if a member objects to provision of any counseling, treatments, or referral services for religious reasons
- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the member the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments which may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies, and poison control centers to provide high-quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research related care
- Inform both PCHP and the HHSC administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.
- 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 within one business day
- PCHP does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

After-Hours Coverage

We encourage PCPs to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.
- Have the office telephone answered after normal business hours by a recording in both English and Spanish. The recorded message should direct the member 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.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone. The person answering the calls must be able to contact the PCP or a designated PCHP network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **NOT** acceptable:

- Answering the office telephone only during office hours
- Answering the office telephone after hours by a recording that tells members to leave a message
- Answering the office telephone after hours by a recording that directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

New Members

We encourage enrollees to select a PCP for preventive and primary medical care, as well as to ensure authorization and coordination of all medically necessary specialty services. Medicaid members age 20 and younger are encouraged to obtain a well-child visit within 90 days of the date of enrollment. Other members are also encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment.

Primary Care Provider Changes and Transfers

We encourage members to remain with their PCPs to maintain continuity of care. However, members may request to change a PCP for any reason by contacting Member Services at 1-888-672-2277 (STAR) or 1-888-814-2352 (CHIP) or TTY 7-1-1. The member's name will be provided to the PCP on the membership roster. Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Specialist as a Primary Care Provider

Under certain circumstances, a member may require the regular care of a specialist. We may approve that specialist to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a disability; special health care needs; or a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must:

- Agree to serve as the member's PCP.
- Meet the requirements for PCP participation (including contractual obligations and credentialing).
- Provide 24/7 access to care.
- Coordinate the member's health care, including preventive care.

When such a need is identified, the member or specialist must contact our Service Coordination department and complete a Specialist as PCP Request form. A Service Coordinator will review the request and submit it to our medical director. We will notify the member and the provider of our determination in writing within 30 days of receiving the request.

The designation cannot be retroactive. If the request is approved, we will not reduce the compensation owed to the original PCP before the date of the new designation of the specialist as PCP. If we deny the request, however, the member may appeal the decision through our member complaint process. Under that process, we must respond to the member's complaint in writing within 30 days. For further information, call Provider Services at 1-888-672-2277.

Provider Marketing

Providers are prohibited from engaging in direct marketing to members to increase enrollment in a particular health plan. The prohibition should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance. Providers must comply with HHSC's marketing policies and

procedures as set forth in Chapter 4.3 of the HHSC Uniform Managed Care Manual, available at **hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual**.

Provider Quality Incentive Programs

We have provider quality incentive programs to reward PCPs and other provider types for the provision of quality medically appropriate health care services to our members. The programs vary by the provider's panel size and use of predefined measures, such as HEDIS® and utilization measures. Providers must be in good standing and meet the eligibility criteria of the given program to participate. For additional information regarding the programs, contact PCHP at **PCHP.ContractingDepartment@phhs.org**.

Radiology

When both a physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading the film. If the physician feels there is a problem with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

Second Opinions

A member, parent, legally appointed representative (LAR), or the member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, surgery options or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the provider directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Referrals

Providers can refer patients to participating providers and facilities when available. If you need to refer a member to an out-of-network provider, you must notify PCHP by requesting a prior authorization. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network.

Help Members Find a Dental Home

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.

Specialty Care Providers

To participate in the Medicaid managed care model, the provider must have applied for enrollment in the Texas Medicaid program. The provider must be licensed by the state before signing a contract with us.

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider (specialist) is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a PCP, within the network. See the specialty care provider roles and responsibilities section for more information. In addition to sharing many of the same responsibilities as the PCP (see Primary Care Provider Responsibilities), the specialist furnishes services that include:

- Allergy and immunology services
- Burn services

- Community behavioral health (e.g., mental health and substance disorder) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers—behavioral health
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Pediatric services
- Perinatal services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

Specialty Care Provider Roles and Responsibilities

Responsibilities of specialists contracted with PCHP include:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information, including source of referral and referral number to PCHP
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and prior authorization of services (if required) at each visit

- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit
- Notifying the member's PCP when scheduling a hospital admission or any procedure requiring the PCP's approval
- Coordinating care (as appropriate) with other providers involved in rendering care for members, especially in cases involving medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist shall:

- Manage the medical and health care needs of members to encompass:
    - Monitoring and following up on care provided by other providers
    - Coordinating referrals to other specialists and other providers (both in- and out-of-network)
    - Maintaining a medical record of all services rendered by the specialist and other providers
- Provide coverage 24 hours a day, 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically and legally and in a culturally competent manner that meets the unique needs of members with special health care requirements
- Participate in PCHP systems that facilitate record sharing, subject to applicable confidentiality and HIPAA requirements
- Participate in and cooperate with PCHP in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by PCHP
- Make reasonable efforts to communicate, coordinate, and collaborate with other specialists (including behavioral health providers) involved in delivering care and services to members
- Participate in and cooperate with the PCHP complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist
- Not balance bill members
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members; this is to occur in accordance with applicable state laws and regulations
- Comply with all applicable federal and state laws regarding the confidentiality of patient records

- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
- Support, cooperate and comply with PCHP Quality Improvement program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform PCHP if a member objects for religious reasons to the provision of any counseling, treatment, or referral services
- Treat all members with respect, dignity, and appropriate privacy; treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations
- Provide members complete information concerning diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments that may be self-administered
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Establish and maintain a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies, and poison control centers to provide quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research-related care
- Within 30 days of occurrence, provide written notice to PCHP if the specialist is named as a party in any civil, criminal, or administrative proceeding; failure to provide timely notice to PCHP constitutes grounds for termination of the specialist's contract with PCHP
- 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 within 1 business day

PCHP does not cover the use of any experimental procedures or experimental medications except under certain pre-certified circumstances.

Texas Vaccines for Children Program

The Texas Vaccines for Children (TVFC) program provides free vaccines for Medicaid and CHIP members from birth through 18 years of age. The free vaccines are provided according to the Recommended Childhood and Adolescent Immunization Schedule established by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Vaccines/toxoids must be obtained from TVFC for eligible members from birth through age 18. Providers must enroll in TVFC to obtain the vaccines.

Cancellation of Product Orders

If a network provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, then the provider must reduce, cancel, or stop delivery at the member's or the member's authorized representative's written or oral request. The provider must maintain records documenting the request.

Reading/Grade Level Consideration

Millions of Americans are functionally illiterate, and many millions more are only marginally literate. Many of our members may have limited ability to understand and read instructions, but most people with literacy problems are ashamed and will try to hide their problem from providers. Low literacy may mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Materials provided to members should be written at a 4th to 6th grade reading level. Be sensitive to the fact that the member may not be able to read instructions for taking medicine or for treatment, and to the embarrassment the member may feel about limited literacy. If interpreter services are needed, call Provider Services at 1-888-672-2277.

Credentialing and Recredentialing

Enrollment Requirements

Providers must be enrolled in Texas Medicaid and credentialed by PCHP with an executed contract to receive reimbursement for services to Medicaid managed care members. Out-of-network providers who are enrolled in Medicaid and obtain prior authorization may receive reimbursement for services to Medicaid managed care members.

Application Process

- PCHP uses Verisys for primary source verification (contact via email, mail, or phone)
- Complete online application for initial credentialing through PEMS+ and for recredentialing through CAQH

- Credentialing approved for three-year periods

Provider Rights

Providers have the right to:

- Complete online application for initial cred through PEMS+ and for recredentialing through CAQH
- Review information obtained during credentialing
- Correct erroneous information
- Check application status by emailing **PCHP.Credentialing@phhs.org**
- Explain discrepancies if necessary

Processing Timeframes

- Initial credentialing: Within 90 days of complete application
- Missing information notification: Within 5 business days
- Expedited credentialing: Claims processing within 30 days for qualifying providers

Expedited Credentialing

Available for providers joining established contracted groups and for specific provider types (physicians, podiatrists, therapeutic optometrists, social workers, counselors, therapists, psychologists) who:

- Are Medicaid-enrolled
- Join a contracted provider group
- Agree to existing group contract terms
- Submit all required documentation

Recredentialing

- Conducted every 3 years
- Considers performance data, complaints, and quality of care
- Non-responsive providers will be terminated
- Extensions available for military service, medical leave, or sabbatical

Reporting Changes

- Notify PCHP 30 days before address or practice status changes
- Recredentialing application updates are not acceptable notification
- Submit changes to **PCHP.Credentialing@phhs.org**

Credentialing Appeals

Credentialing appeals are only applicable to recredentialing events. Providers notified of adverse decisions may request a hearing. PCHP reports upheld adverse actions to appropriate agencies.

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures that come together in a system or agency or among professionals to enable effective work in cross-cultural situations. Cultural competency helps providers and members to:

- Acknowledge the importance of culture and language
- Embrace cultural strengths with people and communities
- Assess cross-cultural relations
- Understand cultural and linguistic differences
- Strive to expand cultural knowledge

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider.

It also impacts the member's adherence to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing, and wellness
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system

Cultural barriers between the provider and the member can impact the patient-provider relationship in many ways, including:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the U.S. health care system

- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

To be culturally competent, we expect providers serving members within this geographic location to demonstrate the characteristics described below.

Cultural Awareness Needed

- The ability to recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others while at the same time maintaining one's objectivity and identity

Knowledge Needed

- Culture plays a crucial role in the formation of health or illness beliefs.
- Culture is generally behind a person's rejection or acceptance of medical advice.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure are culturally unique.
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups.
- Resources, such as formally trained interpreters, should be offered to and utilized by members with various cultural and ethnic differences.

Skills Needed

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and an understanding of other's needs, values, and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action, or speech in the absence of information about a person's culture

- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to utilize culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to recognize challenges related to literacy and provide appropriate and understandable information
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The ability to accept ethnic differences among people and understand how these differences affect the treatment process
- A willingness to work with clients of various ethnic minority groups

Early Childhood Intervention (ECI) Services

We contract with qualified ECI providers to provide ECI covered services to members from birth to 3 years of age who have been determined eligible for ECI services. Members are permitted to self-refer to local ECI service providers without a referral from the member's PCP. Our providers are required to identify and provide referral information to the legally authorized representative (LAR) of any member birth to 3 years of age suspected of having a developmental disability or delay or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108 within 7 calendar days from the day the provider identifies the member.

HHSC provides information and publications on its website at **hhs.texas.gov/services/disability/early-childhood-intervention-services-eci**, which should be used as a resource by providers to identify children in need of ECI services. The local ECI program will determine eligibility for ECI services using the criteria contained in 40 TAC Chapter 108. The member's LAR must be informed that ECI participation is voluntary. PCHP must provide medically necessary services to a member if the member's LAR chooses not to participate in ECI.

The individual family service plan (IFSP) is an agreement developed by an interdisciplinary team that includes the member's LAR, the ECI service coordinator, ECI professionals directly involved in the eligibility determination and member assessment, ECI professionals who will

be providing direct services to the child, and other family members, advocates, or other persons as requested by the LAR. If the member's LAR provides written consent, the member's PCP or PCHP staff may be included in IFSP meetings.

The IFSP identifies the member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is a contract between the ECI contractor and the member's LAR. The LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the member as well as information related to family needs and concerns. If the member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the member with PCHP and the PCP to enhance coordination of the plan of care.

These sections of the IFSP may be included in the member's medical record or service plan. The IFSP is the authorization for the program-provided services (services provided by the ECI contractor) included in the plan. Preauthorization is not required for the initial ECI assessment or for the services in the plan after the IFSP is finalized. All medically necessary health and behavioral health program provided services contained in the IFSP must be provided to the member in the amount, duration, scope and service setting established by the IFSP. Medical diagnostic procedures required by ECI, including diagnostic-specific evaluations so that ECI can meet the 45-day timeline established by federal rule, will be covered by PCHP.

ECI providers must submit claims for all covered services that are program-provided included in the IFSP to us. We must pay claims for ECI-covered services in the amount, duration, scope, and service setting established by the IFSP.

PCHP coordinates with local ECI programs that perform assessment, case management, and non-health-related services required by a member's IFSP when needs are identified or as requested. ECI Targeted Case Management Services and Early Childhood Intervention Specialized Skills Training are not MCO-capitated services as described in the Texas Uniform Managed Care Contract (UMCC), Section 8.2.2.8. PCHP is not responsible for payment of these services; ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP).

Medical Records Standards

Our providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record is maintained at the primary care site for every member and is available to the PCP and other providers. Medical records must be kept in accordance with PCHP and state standards as outlined below.

The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to HIPAA requirements and other federal and state laws. Documentation of each visit must include:

1. Date of service
2. Complaint or purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Treatment plan, tests, and therapies
7. Medications prescribed
8. Health education provided
9. Signature or initials and title of the provider rendering the service; if more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials

These standards will, at a minimum, meet the following medical record requirements:

1. Patient identification information. Each page or electronic file in the record must contain the patient’s name or patient ID number.
2. Personal/biographical data. The record must include the patient’s age, sex, address, employer, home and work telephone numbers, and marital status.
3. Date and corroboration. All entries must be dated and author-identified.
4. Legibility. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. Allergies. Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies [NKA]) must be noted in an easily recognizable location.
6. Past medical history for patients seen three or more times. Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. Physical examination: A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
8. Immunizations. For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.
9. Diagnostic information. Documentation of clinical findings and evaluation for each visit should be noted.

10. Medication information. This notation includes medication information/instruction(s) to the patient.
11. Identification of current problems. Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
12. Instructions. The record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health conditions.
13. Smoking/alcohol/substance abuse. A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
14. Preventive services/risk screening. The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
15. Consultations, referrals, and specialist reports. Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
16. Emergencies. All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
17. Hospital discharge summaries. Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
18. Advance directive. Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision making for individuals who are incapacitated.
19. Security. Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
20. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.

21. Documentation. Documentation is required setting forth the results of medical, preventive, and behavioral health screening and of all treatment provided and results of such treatment.
22. Multidisciplinary teams. Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
23. Integration of clinical care. Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    a. Notation of screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
    b. Notation of screening and referral by behavioral health providers to PCPs when appropriate
    c. Notation of receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals
    d. A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the PCP
    e. A written release of information that will permit specific information-sharing between providers
    f. Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Patient Visit Data

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

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
2. Behavioral health treatment that includes at-risk factors (danger to self/others, ability to care for self, affect/perceptual disorders, cognitive functioning and significant social health) for behavioral health patients
3. An admission or initial assessment that must include current support systems or lack of support systems
4. An assessment for behavioral health patients (performed at each visit) of client status/symptoms regarding the treatment process; assessment may indicate initial

symptoms of the behavioral health condition as decreased, increased, or unchanged during the treatment period

5. A plan of treatment that includes activities/therapies and goals to be carried out
6. Diagnostic tests
7. Therapies and other prescribed regimens for patients who receive behavioral health treatment, including evidence of:
    a. Family involvement, as applicable
    b. Family inclusion in therapy sessions when appropriate
8. Follow-up care encounter forms or notes indicating when follow-up care, a call, or a visit (noted in weeks, months, or PRN) should occur; notes should include the specific time to return with unresolved problems from any previous visits
9. Referrals and results including all other aspects of patient care, such as ancillary services

We will systematically review medical records to ensure compliance with these standards. Compliance with medical record performance standards is a medical record score of 80 percent, including six clinical elements that must be met. Clinical medical record audit and office site visit forms are available on our website at **ParklandHealthPlan.com**.

We will institute actions for improvement when standards are not met. We maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of *45 CFR 74.164* (i.e., records must be retained for seven years from the date of service).

Non-Compliant PCHP Members

Call Provider Services at 1-888-672-2277 if you need help working with a member regarding:

- Behavior
- Treatment cooperation and/or completion
- Appointment compliance

A Member Advocate will contact the member to address the situation with education and counseling. The outcome of the counseling efforts will be reported back to you.

To remove a member from your panel after efforts with the member have been unsuccessful, you must:

- Not make a removal decision based on the member's health status or utilization of services which are medically necessary for treatment of the member's condition
- Send a certified letter to the member or head of household stating that the member must select a new PCP within 30 days of the notice.
- Send a copy of the letter to:

  Parkland Community Health Plan
  ATTN: Member Advocate
  P.O. Box 560347
  Dallas, TX 75356

- Continue to provide care to the member until the effective date of the assignment to a new PCP
- Not take any retaliatory action against a non-compliant member

In extreme situations where a member consistently refuses to cooperate with us and our providers, misuses or loans their member ID card to another person to obtain services, or refuses to comply with managed care restrictions, we may request that HHSC disenroll the member from PCHP.

If the member disagrees with the disenrollment, they may access our member complaint process and the HHSC fair hearing process.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

We strive to ensure that both PCHP and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must implement procedures that demonstrate compliance with the HIPAA privacy regulations.

We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information (such as a member's medical record), which we may request to conduct business and make decisions about care to make an authorization determination to resolve a payment appeal.

Such requests are considered part of the HIPAA definition of treatment, payment, or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access restricted to individuals who need member information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at PCHP, and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to us (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed. Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at PCHP.

Our voicemail system is secure and password-protected. When leaving messages for our associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose. When contacting us, be prepared to verify the provider's name, address, and tax identification number or PCHP provider number.

Medical records standards require 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 HIPAA and other federal and state laws.

Misrouted Protected Health Information

Providers and facilities must review all member information from PCHP to ensure no misrouted protected health information (PHI) is included. Misrouted PHI (information about members a provider is not treating) must be immediately destroyed or safeguarded and must never be misused or redisclosed. If providers cannot destroy or safeguard misrouted PHI, they should contact PCHP Provider Services at 1-888-672-2277 for assistance.

Reporting Abuse, Neglect, or Exploitation (ANE)

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

The provider must provide the MCO with a copy of the Abuse, Neglect, and Exploitation report findings within one business day of receipt of the findings from the Department of

Family and Protective Services (DFPS). In addition, the provider is responsible for reporting individual remediation on confirmed allegations to the MCO.

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

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

Report to Local Law Enforcement

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

Failure to Report or False Reporting

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

Fraud, Waste, & Abuse

As recipients of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect, and deter fraud, waste, and abuse. Our commitment to detecting, mitigating, and preventing fraud, waste, and abuse is outlined in our corporate compliance program. As part of the requirements of the federal Deficit Reduction Act, each PCHP provider is required to adopt our policies on detecting, preventing, and mitigating fraud, waste, and abuse in all the federally and state-funded health care programs in which we participate. Electronic copies of this policy and our Code of Business Conduct and Ethics are available at **ParklandHealthPlan.com**. To meet the Deficit Reduction Act requirements, providers must adopt our fraud, waste, and abuse policies. Additionally, providers must distribute the policies to any staff members or contractors who work with us. If a network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the network provider must:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider; the policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68) (A) of the Social Security Act.
- Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68) (A) of the Social Security Act, the rights of employees to be

protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

Importance of Detecting, Deterring, and Preventing Fraud, Waste, and Abuse

Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types.

Many types of fraud, waste, and abuse have been identified, including the following:

- Provider fraud, waste, and abuse
- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can help prevent fraud, waste, and abuse by ensuring that the services rendered are medically necessary, accurately documented (in medical records), and billed according to American Medical Association guidelines.

Member Fraud, Waste, and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation and/or misrepresentation
- Subrogation and/or third-party liability fraud
- Transportation fraud

To help prevent fraud, waste, and abuse, providers can educate members about the types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is simply reviewing our member identification card. It is the first line of defense against fraud. We may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that

patient presents a PCHP member identification card. Providers should take measures to ensure the patient is the person named on the card.

Additionally, encourage members to protect their PCHP member ID cards as they would a credit card or cash. Members should carry their ID card at all times and report any lost or stolen cards to us as soon as possible.

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

Medicaid Managed Care and CHIP: Do you want to report waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184
- Visit **https://oig.hhsc.state.tx.us/**
  Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form
- You can report directly to your health plan:
  Parkland Community Health Plan
  ATTN: Special Investigations Unit
  P.O. Box 560307
  Dallas, TX 75356
  Phone: 1-800-403-2498

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

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

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

- Dates of events
- Summary of what happened

When reporting about someone who gets benefits, include:

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

Coordination with Texas Department of Family and Protective Services (DFPS)

Providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including providing medical records and scheduling medical and behavioral health services appointments within 14 days, unless requested earlier by DFPS. Providers must comply with the recognition of abuse and neglect and appropriate referral to DFPS.

All covered services defined in court orders or a DFPS service plan must be provided until the member has been disenrolled from PCHP. Reasons for disenrollment include loss of Medicaid managed care eligibility or enrollment in STAR Health (HHSC's managed care program for children in foster care).

Emergency Services

We provide a nurse helpline service with clinical staff to provide triage advice, referral (if necessary) and make treatment arrangements for the member. The service is available 24 hours a day, 7 days a week. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do not discourage members from using the 9-1-1 emergency system and we do not deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as 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:

- Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

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

- 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 response is coordinated with community services, including the following (if applicable):

- Police, fire, and EMS departments
- Juvenile probation
- The judicial system
- Child Protective Services
- Chemical dependency agencies
- Emergency services
- Local mental health authorities

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment. The determination is made by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate the results of the emergency medical screening examination in the member's chart. We will compensate the provider for the screenings, evaluations, and examinations that are reasonable and calculated to assist the health care provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on PCHP. If the emergency department is unable

to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the PCHP concurrent review nurse will implement the concurrent review process to ensure coordination of care.

STAR and CHIP Special Access Requirements

General Transportation and Ambulance/Wheelchair Van

PCHP provides Medicaid members and their attendants non-emergency medical transportation services by the most cost-effective modes to a reasonably close and medically appropriate provider.

Ambulance services are covered for all members in emergencies. Severely disabled members whose conditions require ambulance services will be covered with prior approval. See the STAR covered services chapter for more information.

Over-the-Phone Interpreter Services

PCHP provides language interpretation services to translate multiple languages at no cost to providers or members. This service may be accessed by calling Provider Services at 1-888-672-2277.

People who are deaf or hearing impaired should call TTY 7-1-1 and ask them to call Member Services.

Face-to-Face Interpreter Services

PCHP will arrange, with at least a 72-hour prior notice, to have someone who speaks the member's language meet the patient at the provider's office for their appointment. PCHP will set up and pay for a sign language interpreter to assist members who are deaf or hard of hearing. The service can be arranged by calling Provider Services.

Interpreter services should be requested at least 72 hours before the appointment.

MCO/Provider Coordination

PCHP clinical and operational staff are available to assist you in coordinating care and supporting your care plans for your patients. This includes members who are new to our plan and require transition assistance, have complex or special needs, or need any type of social and/or clinical help. Our provider hotline can assist with PCP assignment or change (including designation of a specialist as PCP), specialist information, and ancillary resource availability.

Our utilization management and case/disease management staff can assist you with out-of-network providers, authorization issues, expedited care requirements, and member-facing support. The latter includes member outreach, education, care coordination, and ongoing guidance.

We can also facilitate coordination with other community programs, including:

- Early Childhood Intervention (ECI)
- Local school districts (special education)
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Texas Department of State Health (DSHS) services, including Title V Maternal and Child Health and Children with Special Health Care Needs (CSHCN) Programs
- Other state and local agencies and programs such as food stamps and the Women, Infants and Children (WIC) Program
- Family planning programs including the Healthy Texas Women, Family Planning, and Primary Health Care Program
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population
- Texas Department of Family and Protective Services (DFPS) Nurse-Family Partnership (NFP)

Contact us at 1-888-672-2277 for assistance with utilization management and service coordination/disease management for your PCHP patients.

Reading/Grade Level Consideration and Cultural Sensitivity

Providers should consider the reading grade level of the member or parent/guardian. As a rule of thumb, any materials that a provider gives to members should not exceed a 6th grade reading level.

Providers should be culturally sensitive to members or parents/guardians. Some actions or words a provider uses may be interpreted by the member or parent/guardian in the wrong way. If you need additional information about cultural sensitivity, contact Provider Services.

Each office is required to ensure compliance with applicable state and federal regulations for handicapped access. The provider must have 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 specialist.

Chapter 5: **Electronic Visit Verification**

General Information About EVV

1. **What is EVV?**
   EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV system documents the following:
   - Type of service provided (Service Authorization Data)
   - Name of the member to whom the service is provided (Member Data)
   - Date and times the visit began and ended
   - Service delivery location
   - Name of the Service Provider or CDS Employee who provided the service (Service Provider Data)
   - Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims

2. **Is there a law that requires the use of EVV?**

   Yes. In December 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.

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

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

   Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.
   EVV Service Bill Codes Table

4. **Who must use EVV?**

   The following must use EVV:

Provider: An entity that contracts with an MCO to provide an EVV service

Service Provider: A person who provides an EVV required service and who is employed or contracted by a provider or a CDS Employer

CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer

Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option

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

EVV Systems

5. Do providers and FMSAs have a choice of EVV systems?

An EVV Vendor System is an EVV system provided by an EVV Vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a provider or FMSA may opt to use instead of an EVV Proprietary System.

- **Data Logic Software Inc.**
- **First Data Government Solutions**

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 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 MC
- Complies with the requirements of Texas Government Code Section 531.024172 or its successors
- **TMHP Proprietary Systems**

6. 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.

7. What is the process for a provider or FMSA to select an EVV system?

To select an EVV vendor from the state vendor pool, a provider or FMSA, signature authority, and the agency's appointed EVV system administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.

TMHP 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.

TMHP EVV Proprietary Systems

8. 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. **TMHP EVV Vendors**
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request

A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV Proprietary System to comply with HHSC EVV requirements.

If selecting either an EVV vendor or an EVV Proprietary System, a provider or FMSA must:

- Complete all required EVV training as described in the answer to Question #18
- Complete the EVV system onboarding activities
  - Manually enter or electronically import identification data
  - Enter or verify member service authorizations
  - Setup member schedules (if required)
  - Create the CDS Employer profile for CDS Employer credentials to the EVV system

9. Does a provider or FMSA pay to use the selected EVV system?

If a provider or FMSA selects an EVV Vendor System, the provider or FMSA uses the system free of charge.

If a provider or FMSA elects to use an EVV proprietary system, the provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a provider or FMSA change EVV systems?

Yes. A provider or FMSA may:

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

11. 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
- 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.

12. 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

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

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

- Manually enter into the EVV system the most current service authorization for an EVV required service, including:

  Name of the MCO
  Name of the provider or FMSA
  Provider or FMSA Tax Identification Number
  National Provider Identifier (NPI) or Atypical Provider Identifier (API)
  Member Medicaid ID
  Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s)
  Authorization start date
  Authorization end date

  - Perform Visit Maintenance if the most current service authorization is not entered into the EVV system
  - Manually enter service authorization changes and updates into the EVV system as necessary
  - EVV Clock In & Clock Out Methods

14. 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.

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
  a smart phone or tablet issued by the provider

- A Service Provider must not use a member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
  - the CDS Employee's personal smart phone or tablet
  - a smart phone or tablet issued by the FMSA
  - 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.

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.

Alternative device

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the member's home.

- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only 7 days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the member's home even during an evacuation.

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

- If a Service Provider does not clock in or clock out of the EVV system or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV system.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV system while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV system.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV system while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV system.
- After the Visit Maintenance time frame has expired, the EVV system locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA, or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV Visit Maintenance

16. 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 the EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. Are providers, FMSAs, and CDS Employers required to include information in the EVV system to explain why they are performing Visit Maintenance?

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

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
- **HHSC EVV Reason Codes**

EVV Training

18. 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
  - 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
  - EVV policy training provided by HHSC, the MCO or FMSA

  Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system
  - EVV system training provided by EVV vendor or EVV PSO

- EVV policy training provided by HHSC, the MCO or FMSA

Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:

- Overview of EVV systems training provided by EVV Vendor or EVV PSO
- EVV policy training provided by HHSC, the MCO or FMSA
- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

PCHP Electronic Visit Verification

EVV Compliance Reviews

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

- EVV Usage Review – meet the minimum EVV Usage Score
- EVV Required Free Text Review – document EVV required free text
- EVV Landline Phone Verification Review – ensure valid phone type is used

PCHP Electronic Visit Verification

EVV Claims

20. 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.

21. Where does a provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.

HHSC Claims Submission Policy

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

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

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

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

24. 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
- Billed units to units on the visit transaction, if applicable

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

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

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch

- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

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

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

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.

If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

TMHP EVV Training

26. 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.

Chapter 6: **Member Eligibility**

Eligibility for Medicaid and CHIP 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

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

- Use TexMedConnect on the TMHP website at **www.tmhp.com**.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling 1-800-252-8263. Members also can go online to order new cards or print temporary cards at **www.YourTexasBenefits.com** and see their benefit and case information, view THSteps alerts, and more.

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

We encourage all providers to verify eligibility and benefits before each service is rendered. Please call PCHP at 1-888-672-2277 or log on to our secure **Provider Portal** to look up claims status, eligibility and authorizations.

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub—regardless of the plan (FFS or managed care). All of this information is collected and displayed in a consolidated form (health summary) with the ability to view additional details if need be. It's free and requires a one-time registration. To access the portal, visit **tmhp.com** and follow the instructions in the Initial Registration Guide for Medicaid Providers. For more information on how to get registered, download the Welcome Packet on the home page. TexMedConnect allows providers to:

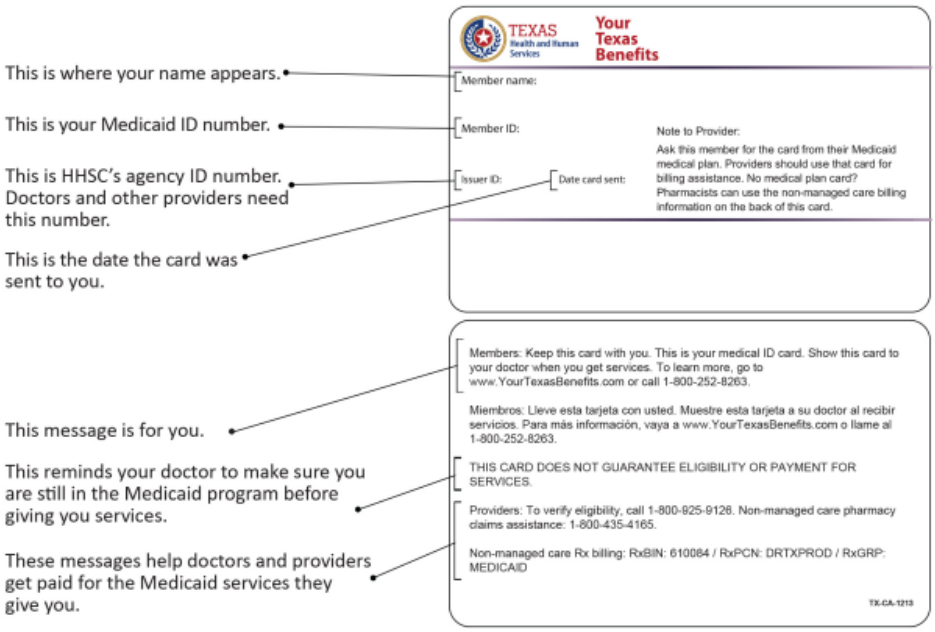
- View available health information such as:
    - Vaccinations
    - Prescription drugs
    - Past Medicaid visits
    - Health events, including diagnosis and treatment

    - Lab results
- Verify a Medicaid patient's eligibility and view patient program information
- View THSteps alerts
- Use the blue button to request a Medicaid patient's available health information in a consolidated format

Patients can also log in to **YourTexasBenefits.com** to see their benefit and case information, print or order a Medicaid ID card, set up THSteps alerts, and more.

If you have questions, call 1-855-827-3747.

Your Texas Benefits Medicaid card example:



A person approved for Medicaid will get a Your Texas Benefits Medicaid card. A member will only be issued one card and will only receive a new card in the event of the card being lost or stolen. If the card is lost or stolen, a member can get a new one by calling toll-free 1-800-252-8263.

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Member's name and Medicaid ID number
- The date the card was sent to the member

- The name of the Medicaid program if the member gets:
    - Medicare (QMB, MQMB)
    - Healthy Texas Women Program
    - Hospice
    - STAR Health
    - Emergency Medicaid
    - Presumptive eligibility for pregnant women (PE)
- What a drugstore will need to bill Medicaid
- The name of the member's doctor and drugstore if the member is in the Medicaid Lock-in program
- The back of the Your Texas Benefits Medicaid card has a website the member can visit (**YourTexasBenefits.com**) and a phone number they can call toll-free (1-800-252-8263) if there are questions about the card. State-issued ID cards are subject to change without notice.

Temporary ID (Form 1027-A)

Providers must accept these documents as valid proof of eligibility. Providers should retain a copy for their records to ensure the person is eligible for Medicaid when the services are provided. Make a copy of both sides. Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form. Providers should check the eligibility date to see whether the client has possible retroactive coverage for previous bills. Current coverage can be verified as described in the verifying member medicaid eligibility section. Members can also go online at **YourTexasBenefits.com** to order a new card or print a temporary card at **hhs.texas.gov/services/questions-about-your-benefits/medicaid-card-questions-answers**.

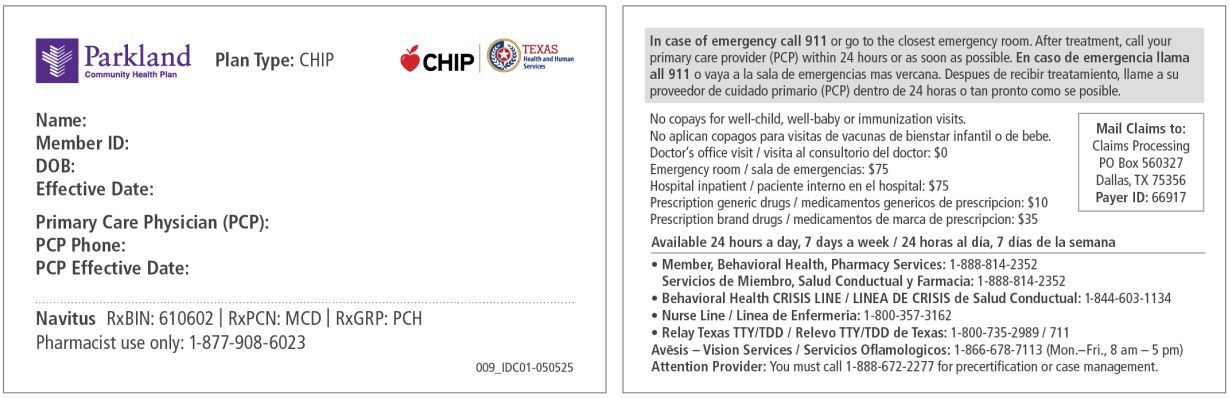
STAR

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 PCHP-assigned number effective on his or her date of birth.

CHIP

Depending upon the member's CHIP category, the copays may vary. Preventive health care services, such as well-child exams and immunizations, are exempt from cost sharing. We will issue a new ID card for those members who have notified the state of Texas that they have met the out-of-pocket annual maximum. The new member ID card will display zero dollars for copays.

Parkland Community Health Plan ID card example:



Service Responsibility

STAR Service Exception Table

We will cover authorized services for all periods for which we have received payment for our members except as indicated in the following table.

Service Category	Description
Newborns	We are responsible for coverage of all covered services for 90 days after birth, including hospital, provider, and non-hospital services costs attributed to the care of a newborn if the mother was enrolled with PCHP on the date of birth.
Hospital Transfers	Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment will not be considered a discharge under this section. For instance, if a member is hospitalized at the time of the plan change, the old plan will be responsible for the hospital services and the new plan will be responsible for the physician services only. This will not change if a member is discharged and readmitted within 24 hours of the discharge. Once the member is discharged, the new health plan is responsible for covering all managed care services.

CHIP Responsibility Table

CHIP-eligible members receive coverage for up to 12 consecutive months and must apply for Medicaid if they are eligible. Most newborns born to CHIP members or CHIP heads of household will be Medicaid eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP eligible, the baby will be covered from the beginning of the month of birth for the period.

Note: There is no spell-of-illness limitation for CHIP members.

Service Category	Description
Pregnant members (including pregnant teens)	We require network providers to notify the plan immediately upon identifying a pregnant CHIP member (excluding CHIP Perinatal). Pregnant CHIP members may be referred for a Medicaid eligibility determination. Those pregnant CHIP members who are determined to be Medicaid-eligible will be disenrolled from CHIP. Medicaid coverage will be coordinated to begin when CHIP enrollment ends to avoid gaps in health care coverage. If we remain unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP. The member's eligibility expiration date will be the latter of: • The end of the second month following the month of the baby's birth • The member's original eligibility expiration date
Newborns	Most newborns born to CHIP members or CHIP heads of household will be Medicaid eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP eligible, the baby will be covered from the beginning of the month of birth for the period.

CHIP Perinatal Responsibility Table

The CHIP program provides certain prenatal and birth benefits to unborn children of pregnant women (adults or teens) not otherwise eligible for Medicaid due to income limits or their immigration status. The program also provides eligibility to the CHIP Perinate woman's newborn child.

CHIP Perinatal provides for 12 months of continuous coverage from the month of the eligibility determination. The mother of the unborn child receives coverage in the prenatal period and through the month of delivery. The child then picks up the remaining months of eligibility. The CHIP Perinate mother has no benefits or eligibility following the child's birth. See the CHIP Perinatal postpartum billing section of this manual for information on claims for postpartum visits.

Under CHIP Perinatal, the unborn child is enrolled prior to birth and remains eligible for the benefits for 12 continuous months from the date of eligibility determination. Subsequent enrollment in traditional CHIP will be subject to the same eligibility and enrollment standards established in traditional CHIP rules.

Once the child is born, the family can submit an application for Medicaid for the newborn if they choose. If eligible, disenrollment from CHIP Perinatal will be coordinated with enrollment in Medicaid.

Children born to CHIP Perinate mothers whose family income is above the Medicaid-eligibility threshold will have the same newborn benefits as those children enrolled in the regular CHIP program after the initial CHIP Perinate newborn admission. Children born into families whose income falls at or below the Medicaid eligibility threshold will be enrolled in Medicaid. There is no spell-of-illness limitation for CHIP Perinate newborn members. Copays/cost sharing does not apply to CHIP Perinate mothers or CHIP Perinate newborns.

Service Category	Description
Families with income at or below the Medicaid eligibility threshold	PCHP is **not** financially responsible for any claims with effective dates of coverage occurring while the child is confined in a hospital. These claims should be submitted to the Texas Medicaid & Healthcare Partnership for processing.
Families with income above the Medicaid eligibility threshold	PCHP **is** responsible for the costs of covered services beginning on the effective date. If a CHIP Perinate newborn is disenrolled while confined in a hospital, our responsibility for the costs of covered services terminates on the date of disenrollment.

Member Enrollment and Disenrollment From PCHP

Medicaid enrollment Medicaid members may enroll in or disenroll from PCHP at any time. If a member asks how to enroll in, or disenroll from PCHP, the provider can direct the member to either method below:

- Call the state enrollment broker, Maximus, at 1-800-964-2777.
- Write to Maximus at the STAR program at: PO Box 149219, Austin, TX 78714-9965.

The effective date of an enrollment or disenrollment is generally no later than the first day of the second month following the month in which a completed enrollment or disenrollment form was received by Maximus. The examples below illustrate how to determine the effective date of an enrollment or disenrollment:

Example 1: Maximus receives the enrollment or disenrollment form by January 15; the effective date is February 1.

Example 2: Maximus receives the enrollment or disenrollment form between January 16 and January 31; the effective date is March 1.

Medicaid Expedited Enrollment of Pregnant Women

Female members eligible for Medicaid under the Type Program 40 (TP40) Pregnant Woman category are eligible for an expedited enrollment as follows:

Certification Date	Enrollment Started
Certified from the 11th through the end of the month	Member will be enrolled on the first day of the month following the month of certification
Certified at any time during their estimated month of delivery	Member will be enrolled the first day of the following month (prospective enrollment)
Certified from the 11th through the end of the month	Member will be enrolled on the first day of the month following the month of certification

The Texas Health and Human Services Commission (HHSC) may retroactively assign an eligible member to us. If a claim is denied, the provider should appeal the claim and include documentation regarding the member's exact enrollment date.

Medicaid Automatic Re-Enrollment

Members who are disenrolled because they are temporarily ineligible for Medicaid are automatically re-enrolled in the same managed care organization (MCO). The member may elect to change MCOs at any time. Temporary loss of eligibility is defined as a period of 6 months or less. We notify our members of this procedure through our member handbooks and newsletters.

Medicaid Managed Care Program Disenrollment

Members who request disenrollment from the mandated managed care program to move back into fee-for-service require medical documentation from the PCP and/or specialist. HHSC renders a final decision on these types of requests. Providers cannot take retaliatory action against a member who decides to disenroll from PCHP.

Medicaid Enrollment Changes During an Inpatient Stay in a Single Hospital

The following table describes payment responsibility for Medicaid enrollment changes that occur during an inpatient stay in a single hospital without transfers, beginning as of the member's effective date of coverage with the new MCO. The responsible party will pay the hospital facility charge until the earlier of the member's date of discharge from the hospital or the loss of Medicaid eligibility. For members who move from STAR, STAR+PLUS, or the Dual Demonstration into STAR Health, the date of discharge from the hospital for behavioral health includes extended stay days as described in the TMPPM.

Scenario	Hospital Facility Charge	All Other Covered Services
Member retroactively enrolled in STAR	New MCO	New MCO
Member prospectively moves from FFS to STAR	Medicaid FFS	New MCO
Member moves between STAR MCOs	Former MCO	New MCO
Member moves from STAR to STAR Health	Former STAR MCO	New STAR Health MCO
Member moves from STAR to STAR+PLUS or Dual Demonstration	Former STAR MCO	New STAR+PLUS or Dual Demonstration MCO
Adult member moves from STAR Health to STAR	Former STAR Health MCO	New STAR MCO

Medicaid enrollment changes due to Supplemental Security Income (SSI) status

When an adult STAR member becomes qualified for SSI, the member will move to either STAR+PLUS or the Dual Demonstration program. When a child STAR member becomes qualified for SSI, the member will move to Medicaid FFS or STAR Kids.

Disenrollment from managed care during an inpatient stay in a hospital

STAR members can move to Medicaid FFS during an inpatient stay in a hospital under limited circumstances regarding disenrollment at the MCO's request. The following table describes payment responsibility in these cases, beginning on the effective date of the member's FFS coverage.

Scenario	Hospital Facility Charge	All Other Covered Services
Member moves from STAR to FFS (disenrolled at MCO's request)	Former STAR MCO	Medicaid FFS

Enrollment changes during a chemical dependency treatment facility stay

The following table describes payment responsibility for Medicaid enrollment changes that occur during a stay in a residential substance use disorder treatment facility or residential detoxification for substance use disorder treatment facility (collectively CDTF), beginning as of the member's effective date of coverage with the new MCO. The responsible party will pay the CDTF charge until the earlier of the member's date of discharge from the CDTF or the loss of Medicaid eligibility. The new MCO may evaluate for medical necessity of the CDTF stay prior to the end of the authorized services period. For members who move from STAR into

STAR Health, the date of discharge from the CDTF includes extended stay days as described in the TMPPM.

Scenario	CDTF Charge	All Other Covered Services
Member retroactively enrolled in STAR	New MCO	New MCO
Member prospectively moves from FFS to STAR	New MCO	New MCO
Member moves between STAR MCOs	Former MCO	New MCO
Member moves from STAR to STAR Health	Former STAR MCO	New STAR Health MCO
Member moves from STAR to STAR+PLUS or Dual Demonstration	Former STAR MCO	New STAR+PLUS or Dual Demonstration MCO
Adult member moves from STAR Health to STAR	Former STAR Health MCO	New STAR MCO

Disenrollment from managed care during a CDTF stay

STAR members can move to Medicaid FFS during a CDTF stay under limited circumstances regarding disenrollment at the MCO's request. The following table describes payment responsibility in these cases, beginning on the effective date of the member's FFS coverage.

Scenario	Hospital Facility Carge	All Other Covered Services
Member moves from STAR to FFS (disenrolled at MCO's request)	Former STAR MCO	Medicaid FFS

Medicaid enrollment changes with custom DME and augmentative device prior authorization

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME, before the delivery of the product.

Scenario	Custom DME	All Other Covered Services
Member moves between STAR, STAR+PLUS, or STAR Health MCOs	Former MCO	New MCO
Member moves from FFS to STAR, STAR+PLUS, or STAR Health MCO	New MCO	New MCO

STAR members enrolled in DADS hospice program

When a STAR member becomes enrolled in the DADS Medicaid hospice program, the member will receive Medicaid services through fee-for-service (FFS) and will be disenrolled from PCHP. HHSC will notify PCHP of the enrollment in the DADS Medicaid hospice program and will initiate prospective disenrollment from managed care and transition the member to FFS.

CHIP Enrollment

Children who enroll in CHIP receive 12 months of continuous coverage. Members must re-enroll annually. If members need assistance with re-enrollment, direct them to call 1-888-814-2352 (TTY: 7-1-1).

CHIP Eligibility

Children under age 19 whose family income falls below 200% of the federal poverty level qualify for CHIP enrollment if they don't meet Medicaid eligibility criteria. CHIP members receive 12-month continuous eligibility once enrolled, with an annual re-enrollment requirement. HHSC's Administrative Services Contractor evaluates and determines all CHIP program eligibility.

CHIP Disenrollment

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

- For any reason within 90 days of enrollment in CHIP
- For cause at any time
- If the member moves to a different service delivery area
- During the member’s annual re-enrollment period, HHSC will make the final decision. Providers cannot take retaliatory action against a member who decides to disenroll from CHIP.

CHIP Perinate Enrollment and Disenrollment

- CHIP Perinate mothers have 15 calendar days from the time the enrollment packet is sent by the vendor to enroll in a managed care organization (MCO). If the mother of the CHIP Perinate member lives in an area with more than one CHIP MCO and does not select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinate member is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

CHIP Perinate Plan Change

- A CHIP Perinate (unborn child) who lives in a family with an income at or below the Medicaid eligibility threshold will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage beginning on the date of birth after the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of the birth covered through emergency Medicaid. Clients under the Medicaid eligibility threshold will receive a Form H3038 with their enrollment confirmations. A Form H3038 must be filled out by the provider at the time of birth and returned to HHSC's enrollment broker.
- A CHIP Perinate unborn member will continue to receive coverage through the CHIP program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.
- If the mother of the CHIP Perinate member lives in an area with more than one CHIP MCO and does not select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.
- When a member of a household enrolls in CHIP Perinate, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinate member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinate member's enrollment period or (2) the end of the traditional CHIP members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP Perinate coverage expires, the child will be added to his or her siblings' existing CHIP case.
- CHIP Perinate members may request to change health plans for any reason within 90 days of enrollment in the CHIP Perinate program, for cause at any time, and if the member moves into a different service delivery area.

CHIP Perinate Disenrollment

HHSC makes final decisions on member enrollment and disenrollment related to CHIP Perinate. Providers cannot take retaliatory action against a member who decides to disenroll from the CHIP Perinate program.

Enrollments and Disenrollments During Hospital Confinement

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

Effective date of SSI status

The Social Security Administration notifies HHSC of a member's SSI status. HHSC will update their eligibility system within 45 days of receiving notice of SSI status for a member. The member will then be able to choose either:

- A prospective move to STAR+PLUS if the member is an adult
- A prospective move to STAR Kids if the member is a child

HHSC will not retroactively disenroll a member from the STAR, CHIP or CHIP Perinate programs.

Chapter 7: **Billing & Claims**

Overview

Providers have three options for submitting claims to PCHP:

- Electronic Data Interchange (EDI)
- Online Provider Portal
- Paper

Timely Filing

Providers must adhere to the following guidelines and time limits for claims to be considered for payment:

- Submit clean claims within 95 calendar days from the date of discharge for inpatient services or within 95 calendar days from the date of service for outpatient services.
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 95 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 95 calendar days for members whose eligibility has not been added to the state's eligibility system.
- Corrected claims must be submitted within 120 days from the date of the Explanation of Payment (EOP).

Note: Claims submitted after the filing timelines outlined above will be denied. We must receive claims from out-of-network providers rendering services outside of Texas within 1 year of the date of service and/or date of discharge.

Coding

Providers must use HIPAA-compliant codes when billing us for electronic, online, and paper claim submissions. When billing codes are updated, the provider is required to use appropriate replacement codes. We will not accept claims submitted with noncompliant codes.

All claims submitted are processed using generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by sources that include the National Correct Coding Initiative, the uniform billing editor, CPT-4 and ICD-10 manuals, and successor documents. In addition, we reserve the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure. Our clinical policies/bulletins are posted on our provider website at **Providers.ParklandHealthPlan.com**.

International Classification of Diseases, 10th Revision (ICD-10) description

ICD-10 is the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaced the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Clean Claim

A clean claim is one submitted for medical care or health care services rendered to a member with the data necessary for PCHP to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837 (claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide
- 837 Institutional Combined Implementation Guide
- 837 Professional Companion Guide
- 837 Institutional Companion Guide

A clean claim is a request for payment for a service rendered by a provider that:

- is submitted timely
- is accurate
- is submitted in a HIPAA-compliant format or using the standard claim form, including a UB-04 CMS- 1450 or CMS-1500 (02-12), or successor forms thereto, or the electronic equivalent of such claim form
- requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by us

Additional clean claim definitions are provided in *21* TAC *21.2803.*

CMS-1500 (02-12) and CMS-1450 (UB-04) must include the following information (HIPAA-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing provider
- Billing provider's taxonomy codes
- NPI of rendering provider
- Rendering provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization/prior authorization number or copy of authorization/prior authorization
- Name of referring physician
- NPI of ordering/referring/supervising provider when applicable
- Any other state-required data
- NDC codes

As part of our compliance with Texas Medicaid/CHIP contract requirements, ordering/referring claim requirements are applied per Texas Government Code §531.024161 and the Texas Medicaid Provider Procedures Manual.

Claims Payment

Clean claims are adjudicated within 30 calendar days of receipt for both institutional and professional claims (18 days for electronic pharmacy claims submission and 21 days for non-

electronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and distribute explanation of payments (EOPs) on a biweekly basis. The EOP delineates the status of each claim that has been adjudicated during the payment cycle.

Paper claims that are determined to be unclean will be returned to the billing provider, along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be returned to the PCHP contracted clearinghouse that submitted the claim.

Deficient Claim

Also known as an unclean claim, a deficient claim is one submitted for medical care or health care services rendered to a member that does not contain the data necessary for the MCO or its subcontracted claims processor to adjudicate and accurately report the claim.

Claim Submission

We encourage electronic submission of claims through EDI. PCHP has designated TriZetto Provider Solutions to operate and service your EDI entry point (EDI gateway).

- The PCHP Payer ID for electronic claims is **Payer ID # 66917**.
- For more information, please email **TTPSSupport@cognizant.com**.
- To submit EDI through TriZetto Provider Solutions, **register or log in to TriZetto**.

Paper Claims Submission

PCHP accepts paper claim submissions on the following forms:

- CMS-1450 (UB-04) claim form for institutional or facility claim submissions
- CMS-1500 (02-12) claim form for professional claim submissions

The forms and instructions are available at the CMS website at **cms.gov**.

Paper claim forms are mailed to:

- Parkland Community Health Plan
  ATTN: Claims
  P.O. Box 560327
  Dallas, TX 75356

Submission for Corrected Claims

For corrected electronic claims, use the following frequency code:

- 7– Replacement of Prior Claim

EDI segments required:

- Loop 2300 – CLM – Claim frequency code
- Loop 2300 – REF – Original claim number

Itemized Bills

An itemized bill is required under the following circumstances:

- Any claim that meets or exceeds the stop-loss provision in the provider agreement

We cannot accept itemized bills with alterations. Altered itemized bills will be returned to the provider with an explanation of the reason for the return. Submit all itemized bills to:

- Parkland Community Health Plan
  ATTN: Claims
  P.O. Box 560327
  Dallas, TX 75356

Capitation

Providers contracted under capitated reimbursement methodologies receive payment on a per-member per-month (PMPM) basis. Payment is issued at the beginning of the month for members assigned to the provider. The payment is adjusted for those members retroactively disenrolled by the state.

Only services outlined in the contract are reimbursed above the capitation payment. Providers receiving capitation are required to submit encounter data for services covered under capitation.

Capitated providers are required to submit encounter claims for all capitation services. PCHP accepts encounter data on the CMS-1500 form or the professional ANSI-837 electronic format. The forms should be completed in the same manner as a claim.

For information about services covered under capitation, call your Provider Services representative.

Provider Reimbursement

PCHP cannot pay providers or assign Medicaid members to providers for Medicaid services unless they are included on the state master provider file as provided by the Texas Medicaid & Healthcare Partnership (TMHP). State master provider files are updated daily.

Federal regulations require state Medicaid agencies to revalidate provider enrollment information every 3-5 years. If a provider's re-enrollment is not complete by the required date, the provider will not be able to receive payments for Medicaid services. Compliance

with the re-enrollment process is solely the responsibility of the provider. Additional information is available through TMHP, the state agency responsible for provider enrollment.

Electronic Funds Transfer and Electronic Remittance Advice

PCHP offers electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers can elect to receive our payments electronically through direct deposit. In addition, providers can select from a variety of remittance information options, including:

- ERA presented online
- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed

Providers have two enrollment options to sign up for EFT:

- **Option 1**: Enrollment with Parkland Community Health Plan only (no fees apply): **enrollments.echohealthinc.com/EFTERAdirect/ParklandCommunityHealthPlan**
- **Option 2**: Enrollment to receive EFT from all payers processing payments on the Settlement Advocated platform (a fee will apply): **enrollments.echohealthinc.com**

Providers can contact ECHO Health at 1-888-927-6260 with additional questions regarding payment options.

Primary Care Provider Reimbursement

We reimburse PCPs according to their contractual arrangement.

Specialist Reimbursement

Reimbursement to network specialty care providers (specialists) and network providers not serving as primary care providers (PCPs) is based on their contractual arrangement with us. Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization. We must be in receipt of the required claims and encounter information.

Overpayments

Overpayments may be identified by PCHP, a PCHP vendor, or the provider. If PCHP identifies the overpayment, a recovery letter will be sent to the provider, and the provider has 45 days to submit a refund check or appeal the refund request. If the provider does not respond within 45 days from the date of the recovery letter, PCHP will begin the recoupment on any

future payments. PCHP is entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us.

Providers can also proactively notify us of an overpayment. It is not uncommon for a provider to identify an overpayment and proactively submit a refund check to reconcile the overpayment amount. Providers must report identified overpayments and submit a refund to PCHP within 60 days from the time of identification. HHSC defines identification as when the provider has or should have, through reasonable diligence, determined that the provider has received an overpayment and quantified the overpayment amount. Overpayments should be reported and refunds submitted using the Refund Information Form located at **Providers.ParklandHealthPlan.com/Resources/Forms**.

Please submit all refund checks with a copy of the Overpayment Refund Notification Form to the following address:

- Parkland Community Health Plan
  ATTN: Refunds
  P.O. Box 560307
  Dallas, TX 75356

Provider-Preventable Conditions

PCHP is required to use the present-on-admission (POA) indicator information submitted on inpatient hospital claims and encounters to reduce or deny payment for provider-preventable conditions.

This includes any hospital-acquired conditions or health care-acquired conditions identified in the Texas Medicaid Provider Procedures Manual. Reductions are required regardless of payment methodology and apply to all hospitals including behavioral health hospitals.

Potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than the natural progression of the underlying medical conditions. Potentially preventable readmissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

HHSC sends reports of PPR and PPC performance to PCHP, including hospital lists, effective dates, and reduction data. We apply those reductions for each hospital on the report, including behavioral health hospitals. PCHP notifies each hospital on the list in writing of the applicable reduction amounts. As a payer of last resort, overpayments are subject to recovery and/or recoupment.

Claim Audits

Except as specified in this section or by future changes in our contract with the state of Texas, we must complete all audits of a provider claim no later than 2 years after receipt of a clean claim, regardless of whether the provider participates in our network. This limitation does not apply in cases of provider fraud, waste or abuse that we did not discover within the 2-year period following receipt of the claim.

In addition, the 2-year limitation does not apply when an examination, audit, or inspection of a provider, by an official or entity that we are required to allow access to records by our contract with the state of Texas, is concluded more than 2 years after we received the claim. Also, the 2-year limitation does not apply when HHSC has recovered a capitation from us based on a member's ineligibility. If any exception to the 2-year limitation applies, we may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, we must make the payment no later than 30 days after the audit is completed. If the audit indicates we are due a refund from the provider, we must send the provider written notice of the basis and specific reasons for the recovery no later than 30 days after the audit is completed. If the provider disagrees with the refund request, we must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights.

Coordination of Benefits

Federal and state laws require Medicaid, including the STAR program, be the payer of last resort. All other available third-party resources (including Medicare) must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of an individual eligible for Medicaid. Providers must submit claims to other health insurers for consideration prior to billing us. A copy of the other health insurer's EOB/EOP or rejection letter should be submitted with the claim to us. If we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue post-payment recovery.

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

We will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases.

Review and research encompasses generating multiple letters and phone calls to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor.

Claims Status and Follow-Up

Providers should check claims status and follow up on claims 30 days after submission. Providers may follow up on their submitted claims by the following methods:

- Obtain claim status via the **PCHP Provider Portal**
- Providers may call our Provider Services Department at 1-888-672-2277, which will offer our Interactive Voice Response (IVR) system to help providers navigate or obtain information that is readily available. The IVR system provides claim status, claims payment information, electronic claims payer ID, paper claims submission address, etc.

Emergency Services Claims

An emergency is defined as any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a lay person possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in:

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

No authorization is required for hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition, as well as services by emergency professional/physicians. This includes a medical screening to evaluate care levels and stabilization services needed to admit or release patient. Neither PCHP nor a provider may hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Authorization is required for post-stabilization services. Emergency service claims are required to follow all claims billing procedures. Claims must identify emergency services with service code 450 or place of service 23.

Integrated Physical and Behavioral Health Care Billing Practices

PCHP billing practices allow integrated providers to bill under one National Provider Identifier (NPI)/Texas Provider Identifier (TPI) for both physical and behavioral health care services, according to the credentials of their providers.

Single NPI/TPI Billing: Integrated provider sites must submit claims under one NPI/TPI for both physical and behavioral health services rendered, based on provider credentials.

Same-Day Billing

1. Providers may bill for both a primary care visit (e.g., office visit E/M code) and a psychotherapy/crisis intervention visit (e.g., 90839, 90840) on the same day.
2. Each service must be distinct and separately documented.
3. Modifier 25 should be appended to the E/M code when behavioral health services are provided during the same visit to denote a significant, separately identifiable service.

Portal Submission

1. Claims for both physical and behavioral health services should be submitted through the PCHP provider portal.

Billing Separation (if applicable): When services must be split, providers must submit distinct claims per line of business specifications.

Specialized Integrated Service Billing

HBAI Services:

1. Bill using CPT codes 96156-96171
2. Submit through the PCHP Provider Portal
3. Include appropriate ICD-10 diagnosis codes demonstrating medical necessity
4. Document the physical health condition being addressed by the behavioral intervention

SBIRT Services:

1. Bill using CPT codes H0049 (screening) and H0050 (brief intervention)
2. Submit through the PCHP Provider Portal
3. Document screening scores and brief intervention content in the medical record
4. Follow Texas Medicaid guidelines for frequency limitations

For detailed information on submitting claims for integrated services, please refer to the PCHP Provider Portal or contact your Provider Relations Representative.

CLIA

The CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable federal requirements and have a CLIA certificate in order to receive reimbursement from federal programs. PCHP will deny claims for CLIA-waived lab services if the Provider does not have a valid CLIA certification on file with Community Health Choice.

Billing for Deliveries and Newborn Services

Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn client's Medicaid number. Claims filed with the mother's Medicaid number cause a delay in reimbursement. PCHP requires separate claim forms for mothers and babies. Every effort should be made to bill claims with the appropriate Medicaid ID number.

Claim forms that reflect combined charges for both a mother and a newborn will be rejected or will be subject to denial. For information regarding billing for deliveries and newborn care for the CHIP Perinate and CHIP Perinate Newborn, please see the section for CHIP in this manual.

To ensure the accuracy of member information and documents related to newborns, PCHP requires providers to complete the **PCHP Newborn Notification form** and the **Texas Standard Prior Authorization form** and fax both documents to 1-844-303-2087 within 3 days of the delivery.

Special Billing

-	-	
School Physicals	STAR & CHIP Only	These services do not need to be provided by the member's PCP but must be performed by a PCHP in-network provider. Claims for these services are billed to PCHP using diagnosis code: Z02.5.
Increased Frame Allowance and Vision Services	STAR & CHIP Only	Claims for these services should be filed directly to Avesis and questions on how to file these claims should be directed to Avesis at 1-866-563-3591.
NEMT	STAR Only	There is no cost to members for the NEMT benefit. Providers are not required to submit claims for these services; PCHP contracts with the transportation vendor who is responsible for billing to PCHP.

Out-of-Network Provider Payments

PCHP will be responsible for out-of-network claims for members with care in progress with nonparticipating providers until the member's records, clinical information, and care can be transferred to a network provider. Payment shall be within the time limits set forth by the state for network providers. Payment allowable shall be comparable to what PCHP pays network providers, an amount negotiated between the provider and PCHP, or the standard nonparticipating rate of 95% of Texas Medicaid. PCHP will be responsible for payment for out-of-network providers who provide covered services to members who move out of the service area through the end of the period for which the state has paid PCHP for that member's care. PCHP expects providers billing for out-of-network emergency care to submit claims within 95 days from the date of service. PCHP will adjudicate "clean" claims submitted for out-of-network emergency care within 30 days from PCHP's receipt of the claim.

Billing Members

Our members **must not be balance-billed** for the amount above that which is paid by us for covered services. In addition, providers may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 95-day filing deadline
- Failure to submit a corrected claim within the 95-day filing resubmission period
- Failure to appeal a claim within the 120-day administrative appeal period
- Failure to appeal a utilization review determination within 30 calendar days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission, or the appeal process

A member cannot be billed for failing to show for an appointment. Providers may not bill PCHP Medicaid members for a third-party insurance copay. Medicaid members do not have any out-of-pocket expense for covered services.

Before rendering services, providers should always inform members that they will be charged for the cost of services not covered by us. A provider who chooses to deliver services not covered by us must:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the client acknowledgment statement, specifying he or she will be held responsible for payment of services.

- Understand he or she may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Private Pay

Providers

- Must advise members they are accepted as private-pay patients, and as such, these members are financially responsible for all services received; providers must advise members of this at the time the service is rendered.
- May bill for any service that is not a benefit of a PCHP program (like personal care items) without obtaining a signed client acknowledgment statement.
- May bill a member as a private pay patient if retroactive eligibility is not granted.
- Must have private pay members agree in writing (see sample documentation shown below) to avoid being asked questions about how the member was accepted; without written, signed documentation that the member has been properly notified of the private pay status, the provider should not seek payment from an eligible program member.

Sample:

"I understand [provider's name] is accepting me as a private pay patient for the period of _____ , and I am responsible for paying for any services I receive. The provider will not file a claim to Medicaid or PCHP for services provided to me."

Signed _____ Date _____

Member Acknowledgment Statement

Providers may bill a PCHP member for a service denied as not medically necessary or not a covered benefit only if all of the following conditions are met:

- The member requested the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgment statement signed by the member and the provider (as shown on the following page); the signed statement must be obtained prior to the provision of the service in question.

Member Acknowledgment Statement Form

I understand my doctor [provider's name], _____, or Parkland Community

Health Plan (PCHP) has said the services or items I have asked for on [date] _____, are not covered under my plan.

PCHP will not pay for these services. PCHP has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if PCHP decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered that I understand I am liable for payment.

Member name (print) _____ Date _____

Member signature _____

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are true:

- The member requests the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgment statement signed by the provider and by the member, above, prior to the service being rendered.

Provider name (print) _____ Date _____

Provider signature _____

Cost Sharing

Medicaid Cost Sharing

Medicaid members do not have copays.

CHIP Cost Sharing

To encourage responsible use of health care services, families are required to share in the CHIP program's cost by paying small copays. Cost-sharing guidelines include:

- Information about copays and annual reporting caps is based on family income; the CHIP member ID card shows the member's copay amount.

- Members must report to Texas CHIP when they or their family reach the annual reporting cap; once the cap is met, the member will be issued a new ID card.
- Upon verbal notification from the member or presentation of an ID card showing that the cost sharing limit has been met, no copay is collected from the member for the balance of the year.

Cost sharing guidelines require that providers:

- Only bill for valid, unpaid copays and non-covered services received by the member
- Promptly refund member overpayments if an incorrect copay was collected for covered services
- Not collect additional payment once the copay is made
- Verify eligibility and copay amounts by calling Provider Services at 1-888-672-2277.

Cost sharing exemptions include:

- Preventive health care services, such as well-baby and well-child exams, immunizations, and pregnancy-related assistance
- Enrollment fees and copays do not apply for Native Americans, Alaskan Natives, CHIP Perinates, and CHIP Perinate Newborn members
- Outpatient office visits for mental health (MH) and substance use disorder (SUD) services and MH/ SUD residential treatment services, in accordance with 42 CFR §457.496(d)(2)
- Copays may not be collected in excess of the cost of a covered service

Co-payments do not apply, at any income level, to:

- Well-baby and well-child care services, as defined by 42 C.F.R. §457.520; preventive services, including immunizations
- Pregnancy-related services
- Native Americans or Alaskan Natives
- CHIP Perinatal members (Perinates (unborn children) and CHIP Perinate Newborns)
- Outpatient office visits for mental health (MH) and substance use disorder (SUD) services and MH/ SUD residential treatment services, in accordance with 42 CFR §457.496(d)(2)

An MCO is not responsible for payment of unauthorized non-emergency services provided to a CHIP member by an out-of-network provider. In such circumstances, the CHIP member will be responsible for all costs.

Refer to the CHIP and CHIP Perinate covered services chapter for additional information on CHIP benefits, limitations, and exclusions.

CHIP Cost Sharing Schedule

Copay information is shown in the table below:

Enrollment Fees (for 12-month enrollment period)	Charge
At or below 151 percent of FPL*	$0
Above 151 percent up to and including 186 percent of FPL	$35
Above 186 percent up to and including 201 percent of FPL	$50
Copays (per visit):	
At or below 151 percent of FPL	**Charge**
Office visit (non-preventive)	$5
Nonemergency ER	$5
Generic drug	$0
Brand drug	$5
Facility copay, inpatient (per admission)	$35
Cost-sharing cap	5 percent (of family's income)**
Above 151 percent up to and including 186 percent of FPL	**Charge**
Office visit (non-preventive)	$20
Nonemergency ER	$75
Generic drug	$10
Brand drug	$35
Facility copay, inpatient (per admission)	$75
Cost-sharing cap	5 percent (of family's income)**
Above 186 percent up to and including 201 percent of FPL	**Charge**
Office visit (non-preventive)	$25
Nonemergency ER	$75
Generic drug	$10
Brand drug	$35
Facility copay, inpatient (per admission)	$125
Cost-sharing cap	5 percent (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

Providers Required to Report Overpayment

When a claim overpayment is discovered, PCHP will notify the provider. If a provider is notified by PCHP of an overpayment, or discovers that they have received an overpayment, the provider should return the overpayment to PCHP by mailing a check and a copy of the overpayment notification to:

- Parkland Community Health Plan
  ATTN: Refunds
  P.O. Box 560307
  Dallas, TX 75356

Chapter 8: **Utilization Management**

Overview

PCHP operates a comprehensive utilization management (UM) program known as prior authorization and UM. Our UM program facilitates the delivery of the most appropriate medically necessary care, benefits, and services to our eligible members in the most appropriate setting while ensuring our members receive clinically appropriate care and services in the most efficient manner possible.

For services that require prior authorization, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria.

The UM program includes activities related to inpatient and ambulatory care. Through collaboration with other programs such as care coordination, discharge planning, case management, and community programs, we ensure we meet the physical, behavioral, and social needs of our members.

We provide medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

Regarding UM issues, staff are available at least eight hours a day Monday through Friday during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within 1 business day. Our staff will identify themselves by name, title, and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

For questions about UM processes, including requesting a free copy of our UM criteria, contact the Provider Services line at 1-888-672-2277.

Medical Review Criteria

As a health plan and individuals involved in UM decisions, PCHP is governed by the following statements:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- PCHP does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

PCHP utilizes nationally recognized, evidence-based medical policies and clinical UM guidelines. These policies are publicly available on our website at **Providers.ParklandHealthPlan.com/Prior-Authorization**

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. Medical policies, clinical UM guidelines, and medical drug benefit clinical criteria are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting prior authorization and claim decisions through our website at **Providers.ParklandHealthPlan.com/Prior-Authorization**

In addition, the following criteria/guidelines may be used:

- Texas Medicaid Provider Procedures Manual (TMPPM)
- Evidence-Based Clinical UM guidelines, InterQual.
- Behavioral Health utilizes the American Society for Addiction Medicine Patient Placement Criteria (ASAM) for substance use treatment authorizations with the exception of detoxification, which uses InterQual
- PCHP Medical Policies
- Clinical peer reviewers may additionally utilize evidence-based guidelines recognized by the American Board of Medical Specialties (ABMS) such as the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American Medical Association.

Medical Director Expertise

If we modify the medical review criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development
- Criteria are based on review of market practice, national standards, and best practices

- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated

Our utilization reviewers use these criteria as part of the prior authorization of scheduled admission, concurrent review, and discharge planning processes. The criteria enable reviewers to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

Prior authorization (PA) is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request.

Prospective means the coverage request occurred prior to the service being provided.

Notification occurs prior to rendering covered medical services to a member. The provider must notify us by telephone or by fax of the intent to render covered medical services. For emergency services, notification should be given within 24 hours or the next business day. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified.

Federal law, state law, and contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. State Medicaid contracts or CMS requirements will supersede both PCHP medical policy and InterQual level-of-care criteria. Medical technology evolves constantly, and we reserve the right to review and update medical policy and UM criteria.

Prior Authorization Process

For services requiring prior authorization (PA), PCHP makes determinations considering the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria. To determine if PA or notification is required, see our Prior Authorization Lookup Tool at **Providers.ParklandHealthPlan.com/Prior-Authorization/Lookup-Tool**.

For services requiring PA, PCHP makes determinations considering the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care and

medical necessity criteria. To determine if PA or notification is required, see our Prior Authorization Lookup Tool at **providers.parklandhealthplan.com/prior-authorization/lookup-tool**.

A completed PA request is required to eliminate delays in processing, which includes all required documentation, current clinical information, and a signed authorization form by the requesting provider. Documentation and forms required for PA requests are located on our provider website.

PA requests or notifications can be submitted digitally through the **Provider Portal** (preferred method).

Additional information regarding the process to submit PA requests is located in the Quick Reference Information section of this manual.

Information needed for a member that is hospitalized

For services or equipment that will be necessary for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the Discharge Planning section of this manual.

Submission timelines

Initial requests for PA with all supporting documentation are recommended to be submitted a minimum of three business days prior to the start of care.

For timeline exceptions, please refer to the provider website for PA requirements.

Failure to comply with notification rules may result in an administrative denial. Additional information is available in the Administrative Denials section of this manual.

Prior authorization review

Upon receipt of a request for PA, PCHP staff verifies eligibility and benefits prior to forwarding to the nurse or other qualified reviewer. The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures using criteria/guidelines. When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting provider.

Prior authorization not required

If a request is submitted for a service for which PA is not required, the provider will receive a response stating that PA is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations and patient eligibility at the time services are rendered.

Incomplete documentation

If the PA documentation is incomplete or inadequate, the reviewer is unable to process the request. In such instances, we will notify the provider and member to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the medical director will make a determination based on the information previously received.

Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial. For information on this process, refer to the Peer-to-Peer Review Process section of this manual.

Prior authorization recertification process

A physician or health care provider can submit a medical PA recertification request at least 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exception: PCHP requires that the following PA recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s):

- Physical, Occupational, and Speech Therapy
- Private Duty Nursing (PDN)
- Prescribed Pediatric Extended Care Centers (PPECC)

Determination Timelines

Where regulatory and accreditation standards differ, the strictest or shortest timeframe is utilized to assure compliance with all requirements.

Program	Authorization Type	Turnaround Time
Medicaid	Routine/Non-Urgent	3 business days
CHIP	Routine/Non-Urgent	2 business days (approval) 3 business days (adverse determination)
Medicaid & CHIP	Urgent/expedited	3 calendar days

Medicaid notifications:

A written notice of final determination will be provided no later than the next business day following a PA request determination

CHIP notifications:

- For a member that is not hospitalized at the time of an adverse determination, notification will be provided within 3 business days in writing to the requesting provider and the member.

- For routine and urgent approvals, written/letter notification is required no later than the second business day after the date of the request.

Medicaid/CHIP:

- For a member who is hospitalized at the time of the request, within 1 business day of receiving the request for services or equipment that will be necessary for the care of the member immediately after discharge, including if the request is submitted by an out-of-network provider, provider of acute care inpatient services, or a member.
- Within 1 hour of receiving the request for post-stabilization or life-threatening conditions, except for emergency medical conditions and emergency behavioral health conditions where PA is not required.
- Providers can confirm that an authorization is on file by accessing the Provider Portal or calling Provider Services at 1-888-672-2277. If coverage of an admission has not been approved, the facility should contact Provider Services to resolve the issue.

Expedited Requests

A member or physician may request to expedite a determination when the member, or member's physician, believes that waiting for a decision under the standard time frame could cause any of the following:

- Serious jeopardy to the life, health, or safety or the member's ability to regain maximum function, based on a prudent layperson's judgment
- Serious jeopardy to the life, health, or safety of the member or others, due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus
- In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member

The following situations are examples that do not meet criteria for an expedited request:

- The date of service is greater than one week from the request date
- Clinical documentation does not support criteria for an expedited request as defined above
- Any request for therapy (occupational, speech, or physical therapy) greater than 2 days from the request date

Request for services as "Urgent," "Expedited," or "STAT" are processed as non-urgent if the request does not meet Expedited/Urgent/STAT as defined above.

Peer-to-Peer Review Process

The P2P consultation is available when a PA request is under review and may result in an adverse determination. The consultation occurs between the requesting provider and PCHP Medical Director. PCHP notifies providers via fax and offers a reasonable opportunity for a P2P consultation before issuing an adverse determination. The letter includes the member's name, ID#, DOB, authorization number, the phone number to call the Medical Director, and the time the consultation expires. If you reach our Medical Director's voicemail, leave your name, best contact number, authorization number, and a convenient time to call back. The Medical Director will make every effort to return calls within 1 business day.

Administrative Denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, failure to obtain a prior authorization, or benefit limitations.

If the health plan overturns its administrative decision, the case will be reviewed and, if approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary to ensure a seamless transition from the inpatient setting to outpatient services to improve health outcomes for our members.

Our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's provider(s) regarding follow-up care after discharge, and the provider is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending facility is also responsible for ensuring the member has secured an appointment for a follow-up visit with a HEDIS qualified behavioral health provider. The follow-up visit must occur within 7 calendar days of discharge.

When additional or ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Contact Numbers (fax)

Inpatient Discharge Planning — Physical Health:
214-266-2084 or toll-free 1-844-303-2807

Inpatient Discharge Planning — Behavioral Health:
214-266-2097 or toll-free 1-844-306-2430

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include but are not limited to transportation, home health, durable medical equipment (DME), pharmacy, follow-up visits to practitioners, and outpatient procedures.

Retrospective Review

A retrospective review is any review of care or services that have already been provided. PCHP will review post-service requests submitted by clinicians for authorization of inpatient admissions or outpatient services if the request is received within 30 calendar days of the date of service, and either of the following extenuating circumstances are met:

- Unable to know the situation—The clinician and/or facility is unable to identify from which health plan to request an authorization. The member is not able to tell the clinician about their insurance coverage, or the clinician verified different insurance coverage prior to rendering services.
- Not enough time situations—The member requires immediate medical services and the clinician is unable to anticipate the need for a pre-authorization immediately before or while performing a service.
- A member is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

Confidentiality of Information

UM, service coordination, disease management, discharge planning, quality management, and claims payment activities are designed to ensure that patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct UM and other activities and processes listed above.

Self-Referrals

Service	Authorization for Continued Services
Obstetric/gynecological services	• One well-woman checkup each year • Care related to pregnancy • Care for any female medical condition Referral to specialist doctor within the network
Texas Health Steps	Members may self-refer to any THSteps certified provider.
Emergency Care	No prior authorization or notification is required, regardless of network status with PCHP.
Tuberculosis, sexually transmitted diseases, HIV/AIDS testing and counseling services	No prior authorization or notification is required for these services, regardless of network status with PCHP.
Behavioral health (non-participating providers must seek prior approval from PCHP)	Members may self-refer to any network behavioral health services provider. No prior approval from the PCP is required. Members or providers who need assistance in identifying specialists in the PCHP network may obtain a list by calling PCHP at 1-888-672-2277 or using the **provider look-up tool** available on the PCHP website at **ParklandHealthPlan.com.**
Early Childhood Intervention (ECI)	Members may self-refer to local contracted ECI service providers. PCHP providers must provide referral information to the legally authorized representative of any member from birth to 3 years of age suspected of having a developmental disability or delay, or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108, within 7 calendar days from the day the provider identifies the member.
Family planning/sexually transmitted disease (STD)	No prior authorization or notification is required for these services.
Sterilization	No prior authorization or notification is required. Providers must submit claims with the Sterilization Consent Form. Claims submitted without the form will be denied.

Chapter 9: **Member Management Support**

Appointment Scheduling

PCHP, through participating providers, ensures members have access to primary care services for routine, urgent, and emergency needs, as well as specialty care services for chronic and complex care. Providers should respond to PCHP members' needs and requests in a timely manner. PCPs should make every effort to schedule our members for appointments using the guidelines outlined in the Provider Rights and Responsibilities chapter of this manual.

Service Coordination

Program Overview

Our Service Coordination program is part of a comprehensive healthcare management services program offering a continuum of services including service coordination and disease management. The program helps reduce barriers by identifying members' unmet needs and assisting them in meeting those needs. This may involve coordinating care, helping members access community resources, providing disease-specific education, or implementing interventions designed to allow members to live as safely and independently as possible. These programs make more efficient use of limited healthcare resources.

The role of the Service Coordinator is to provide members with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance well-being, independence, and community integration.

Key Functions of Service Coordination

1. Conduct detailed member assessments and identify care needs to include, but not limited to, physical health, mental health services, and long-term support service needs
2. Develop a comprehensive service plan to address member needs—this includes coordination with treating providers and other participants of the member’s care team. The team must include both physician and non-physician providers that the PCP determines are necessary for the comprehensive treatment of the member. The team must:
    - participate in hospital discharge planning
    - for behavioral health hospitalizations, participate in discharge planning

- participate in pre-admission hospital planning for non-emergency hospitalizations
- develop specialty care and support service recommendations to be incorporated into the service plan
- provide information to the member, or when applicable, the member's authorized representatives or LAR concerning the specialty care recommendations

3. Assist the member to ensure timely and coordinated access to providers and covered services
4. Assist the member with the identification and coordination of community supports as needed and educate on available community resources for services that may not be part of the benefit package
5. Active and ongoing member and provider engagement, as needed
6. Coordination of covered services and non-Medicaid covered services, as necessary and appropriate

In general, members are initially identified for service/care coordination through a review of state data, analysis of claims history and health risk assessments. Members are also identified through HHSC, providers, and member self-referral.

Objectives of the Service Coordination Program

- Maintain a comprehensive case management system to manage the needs of members with high service coordination needs in one or more domains (physical, behavioral, or social)
- Utilize targeted high-intensity interventions that include the option of in-person interactions with a specific identified group of members define by the state as "super-utilizers" due to excessive utilization patterns
- Identify barriers that may impede members from achieving optimal health
- Implement agreed-upon interventions to increase the likelihood of improved health outcomes, improving quality of life
- Reach out to effectively engage members and their families as partners in the service coordination process
- Reduce unnecessary, duplicated, and/or fragmented utilization of health care resources
- Promote collaboration and coordination (at all levels of the health care delivery system) between physical health, behavioral health, the pharmacy program, and community-based social programs

- Foster improved coordination and communication among providers and with PCHP staff
- Improve member and provider satisfaction and retention
- Comply with applicable contractual and regulatory requirements related to care coordination
- Identify opportunities to transition members to more appropriate federal/state programs (e.g., from STAR to STAR Kids or STAR+PLUS)
- Serve as advocates for members
- Assist members to match available benefits to their health care needs
- Promote effective strategies to prevent or delay relapse or recurrence through interventions, such as member education and improved member self-management
- Coordinate service coordination interventions with ongoing health promotion initiatives, such as dissemination of member education literature
- Help members and their families mobilize internal and external resources and strengths to improve their health outcomes and manage the costs of care
- Provide culturally competent service coordination to members, families, and providers
- Maintain the highest quality of ethical standards, including maintenance of confidentiality, in all dealings with members
- Conduct quality management and improvement activities to ensure the highest possible level of service to members and their families
- Monitor outcomes of interventions to assist in evaluating and improving programs

Eligibility for Service Coordination

Any PCHP member classified as high-risk or designated as a Member with Special Health Care Needs (MSHCN) who is interested in receiving service coordination will receive these services.

The following members are considered high-risk or members with special healthcare needs:

- Members receiving Early Childhood Intervention services
- High-risk pregnant women
- Pregnant members with a previous pre-term birth
- Members with high-cost catastrophic cases or high service utilization
- Members with mental illness and co-occurring substance use disorder
- Members with a behavioral health diagnosis or condition that may affect a member's physical health or treatment compliance, including members with serious emotional disturbance or serious and persistent mental illness
- Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic or

pharmacological intervention and evaluation (e.g., HIV/AIDS, respiratory illness, diabetes, heart disease, or kidney disease, or members receiving ongoing therapy or in-home/facility nursing or attendant care)

Comprehensive Member Assessment

A service coordinator conducts a comprehensive assessment to further determine a member's needs. The assessment will include a range of questions identifying and evaluating the member's, including:

- Summary of current medical and social needs
- Functional status
- Goals
- Life environment
- Natural strengths and supports, such as the member's abilities or family members
- Emotional status
- Self-care capability
- Current treatment plan (covered and non-covered services, community supports, and other resources)

Using the structured assessment tool, service coordinators conduct telephone interviews or arrange for a home visit to collect and assess information from the members or their representatives. To complete the assessment, service coordinators obtain information from the PCPs and specialists, our continuous case-finding information, and other sources to coordinate and determine current medical needs and non-medical services needed. This information is used to develop a comprehensive individualized service plan.

Hours of Operation

Our service coordinators are licensed nurses and social workers available Monday through Friday from 8 am to 5 pm Central time. Confidential voicemail is available 24 hours a day.

Contact Information

To contact a service coordinator, call Service Coordination at 214-393-7003. Providers may also contact the service coordination team via email at **PCHPUMCaseMangement@phhs.org**.

Members with Special Health Care Needs (MSHCN)

MSHCN means a member who:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time

- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel
- Complex Care - has two or more chronic conditions

MSHCN also include the following:

- Early Childhood Intervention program participants
- Farmworker children
- Former foster care children
- Pregnant women who have a high-risk pregnancy
- Members that have a mental illness with substance abuse
- Members with behavioral health issues that may affect physical health or treatment compliance
- Adoption Assistance and Permanency Care Assistance (AAPCA) program members
- Members with high-cost catastrophic cases or high service utilization, such as a high volume of ER or hospital visits.

We have an established system for identifying and contacting members who may have special health care needs. Members may also request an assessment to determine if they meet the criteria for MSHCN.

For members identified as MSHCN, we provide service coordination. This includes the development of a service plan to ensure the provision of covered services to meet the special preventive, primary acute care and specialty health care needs appropriate for treatment of the member's condition, and access to treatment by a multidisciplinary team when needed.

MSHCN members may also have a specialist designated to serve as a PCP (see the specialist as a PCP section for more information).

To refer a patient who may qualify as having special health care needs, contact Service Coordination at 214-393-7003. Providers may also contact the service coordination team via email at **PCHPUMCaseMangement@phhs.org**.

Communicable Disease Services

PCHP covers communicable disease services to members. These services help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs), and HIV/AIDS infection.

Members can receive TB, STD, and HIV/AIDS services outside our provider network through Texas Department of Health and Environmental Control clinics without restrictions. Providers

should encourage members to receive these services through PCHP to ensure continuity and coordination of care.

Providers must report all known cases of TB, STD, and HIV/AIDS infection to the state public health agency within 24 hours, regardless of whether the case is also reportable by laboratories.

Control and Prevention of Communicable Diseases

PCHP coordinates with public health entities in each service area regarding essential public health services. We meet the following requirements:

- Report communicable diseases and diseases preventable by immunization as defined by state law
- Notify local public health entities of communicable disease outbreaks involving members
- Coordinate with local public health entities or DSHS regional staff for follow-up of suspected or confirmed childhood lead exposure cases

Health Promotion

PCHP strives to improve healthy behaviors, reduce illness, and enhance quality of life through comprehensive programs. Educational materials are provided to members, and health education classes are coordinated with PCHP-contracted community organizations and network providers.

We offer our members health education and information through:

- Member newsletters that include information on condition management, healthy pregnancies, and postpartum care
- Disease-specific health education webinars, events, and targeted campaigns
- Partnerships with community-based organizations to enhance member opportunities

Women, Infants, and Children Program (WIC)

The Women, Infants, and Children (WIC) program provides supplemental foods and nutrition education to:

- Pregnant women
- Breastfeeding women
- Women who have had a baby in the past six months
- Parents, stepparents, and foster parents of infants and children age 4 and younger

The members above are automatically eligible for WIC services if they:

- are Medicaid-eligible
- have a family income up to 185 percent of the federal poverty level

Providers must coordinate with the WIC Special Supplemental Nutrition program to provide medical information necessary for WIC program operations, such as height, weight, hematocrit or hemoglobin. Call 1-800-942-3678 for program details.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) is a Medicaid benefit that provides health-related case management services to children from birth through 20 years of age with a health condition and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services. For additional information, providers may refer to **hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women.**

Who can get a case manager?

Children, teens, young adults (birth through age 20), and pregnant women who get Medicaid and:

- have health problems or
- are at a high risk for getting health problems

What do case managers do?

A case manager will visit with the member to:

- find out what services they need
- find services near where they live
- teach them how to find and get other services
- make sure they are getting the services they need

What kind of help can members get?

Case managers can help members:

- Get medical and dental services
- Get medical supplies or equipment
- Work on school or education issues
- Work on other problems

How can a member get a case manager?

They can call PCHP at 1-888-672-2277 (STAR) or 1-888-814-2352 (CHIP) and ask to speak to a case manager for children and pregnant women.

Disease Management Program

PCHP provides disease management services (also called condition management services) for CHIP and STAR members. Our condition management services are based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. Condition management services include a holistic, member-centric approach that allows care managers to focus on multiple needs of members. We identify members at highest risk of utilization of medical services, tailor interventions to better meet members' needs, and apply best practice protocols for individualized care. Our condition management programs include:

- Asthma
- Diabetes

PCHP's condition management program offers education, coaching, and other services that can help members better manage their health. Our goal is to help our members with diabetes and asthma self-manage their condition, develop and implement better lifestyle choices, reduce the risks of health complication, reduce preventable hospital visits and promote ongoing healthy living.

Maternity Management Program

PCHP is committed to providing its members with a proactive prenatal care program that promotes early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The goal of the PCHP prenatal program is to improve the birth and health outcomes of all pregnant members.

The PCHP prenatal program supports the practitioner-patient relationship and member's treatment plan and emphasizes the prevention of complications using evidence-based clinical guidelines and patient empowerment strategies. The PCHP prenatal program strives to improve the frequency of prenatal and postpartum care, as well as reduce the incident of low birth weight, preterm deliveries, and neonatal intensive care unit (NICU) admissions. To understand and effectively address existing disparities in health and disease patterns, the program takes into account the physical health, behavioral health, and social needs that influence the member's well-being, particularly during pregnancy and the postpartum period.

To refer your patients to the PCHP maternity management program, please call the Service Coordination department at 214-393-7003. Providers may also contact the service

coordination team via email at **PCHPUMCaseMangement@phhs.org** or complete a Member CM/DM referral form through the **PCHP Provider Portal**.

Who is eligible?

All members with diagnoses of the above conditions are eligible for Disease Management services. Members are identified through activities such as continuous case-finding, welcome calls, and referrals.

Referring patients to Disease Management programs

As a valued provider, you can refer patients who can benefit from additional education and service coordination support.

Program features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status
- Continuous patient self-management education including:
- primary prevention
- behavior modification programs and compliance/surveillance
- home visits and service coordination for high-risk members

Our Disease Management programs are based on nationally approved clinical practice guidelines, located at **Providers.ParklandHealthPlan.com/Resources/PCHP-Information**. Providers can print a copy of the guidelines from the PCHP website or request a copy by calling Provider Services at 1-888-672-2277.

Our service coordinators will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their disease. Program evaluation, outcome measurement, and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

Hours of Operation

Our service coordinators are licensed nurses and social workers. They are available Monday through Friday, 8 am to 5 pm Central time.

Confidential voicemail is available 24 hours a day. A nurse helpline is available to our members 24 hours a day, 7 days a week.

Disease Management Provider Rights and Responsibilities

You have the right to:

- Have information about PCHP, including:
    - provided programs and services
    - our staff
    - our staff's qualifications
    - any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients
- Be informed of how we coordinate our interventions with your patients' treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about our Disease Management program as outlined in the PCHP provider complaint procedure

Chapter 10: **Behavioral Health**

Definition of Behavioral Health

Behavioral health services are covered services for the treatment of mental, emotional, or substance use disorders. PCHP provides coverage of medically necessary behavioral health services as outlined in this chapter.

Behavioral Health Covered Services

Medicaid-covered behavioral health services include, but are not limited to:

- Inpatient mental health services (services may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting)
- Outpatient mental health services including:
    - Assessment
    - Individual, family, and group therapy
    - Psychiatry services
    - Applied Behavior Analysis (ABA)
    - Psychological and neuropsychological testing
- Mental health rehabilitative services
- Mental health targeted case management
- Outpatient substance use disorder treatment services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy
- Inpatient and residential substance use disorder treatment services, including withdrawal management/detoxification services
- MH and SUD intensive outpatient programs (may be provided in lieu of inpatient)
- MH and SUD partial hospitalization (may be provided in lieu of inpatient)
- Coordinated Specialty Care (may be provided in lieu of inpatient)

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional fee-for-service (FFS) Medicaid coverage. The services may be subject to the MCO's non-quantitative treatment limitations provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

Attention Deficit Hyperactivity Disorder (ADHD)

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as an outpatient mental health service. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the **Texas Medicaid Provider Procedures Manual**. Providers should complete follow-up visits with members receiving these medications including a minimum of a 1-month follow-up of the first fill of the prescription and two subsequent office visits over the next 9 months.

In Lieu of Services (ILOS)

In lieu of services (ILOS) are those offered in lieu of covered Medicaid state plan services. PCHP offers specific services, as noted above, in lieu of acute inpatient care when clinically appropriate. ILOS are voluntary options for members when medically appropriate and cost-effective; members must agree to receive ILOS before the services are provided. The intent of providing CSC, partial hospitalization services, or IOP services as an ILOS is to prevent or reduce inpatient hospitalization. However, there may be cases where inpatient hospitalization is medically necessary.

As providers encounter members in need of ILOS, they must notify them of the availability of appropriate service(s). Providers must contact PCHP to request authorization for these services by phone at 1-888-672-2277, by fax at 214-266-2064 or (toll-free) 1-844-266-2064, or via the Provider Portal. PCHP will work with members and providers to access and authorize the services that are clinically indicated. The provider must document communication with the member about ILOS and that the member is voluntarily agreeing to receive ILOS in the medical record.

CHIP covered behavioral health services include but are not limited to:

- Inpatient mental health
- Outpatient mental health, including:
    - Assessment
    - Individual, family, and group therapy
    - Psychiatry services
    - Psychological and neuropsychological testing
- Mental health rehabilitative services
- Mental health targeted case management
- Outpatient substance use disorder treatment services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy

- Inpatient and residential substance use disorder treatment services, including withdrawal management/detoxification services
- MH and SUD intensive outpatient programs
- MH and SUD partial hospitalization
- Coordinated Specialty Care

These services are not covered for CHIP Perinate members (unborn children).

MCO Responsibility for Authorized Inpatient Hospital Services

PCHP is responsible for authorized inpatient hospital services, including services provided in freestanding psychiatric facilities for children in STAR.

Primary Care Provider Requirements for Behavioral Health

Primary care providers (PCPs) can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a behavioral health provider
- The member is willing to be treated by the PCP
- The services rendered are within the scope of the benefit plan

Member Access to Behavioral Health Services

Members have access to the following behavioral health services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions
- Behavioral health service coordinators to work with hospital discharge planners
- Support and assistance for network behavioral health care providers

Self-Referral

Our members can self-refer to any participating behavioral health provider by calling Member Services at 1-888-672-2277 (STAR) or 1-888-814-2352 (CHIP) or TTY 7-1-1. No prior authorization or referral is required from the PCP.

Prior Authorization and Referrals for Behavioral Health

Providers may request prior authorization or refer members for services by:

- Calling Provider Services at 1-888-672-2277
- Faxing information to our behavioral health fax line at 214-266-2064 or (toll-free) 844-266-2064 for all services
- Visiting the **PCHP Provider Portal**

PCP Referral

PCPs should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment
- Educate members about the relationship between physical and behavioral health conditions
- Contact a behavioral health clinician when behavioral health needs go beyond their scope of practice
- Use validated behavioral health screening instruments such as the PHQ-9 and GAD-7

Coordination Between Behavioral Health and Physical Health Services

PCHP maintains a behavioral health provider network that includes psychiatrists, psychologists, and other behavioral health providers experienced in serving children, adolescents, and adults. PCHP requires clinical coordination between Behavioral Health Service Providers and Primary Care Providers (PCPs) to ensure members receive appropriate care for both physical and behavioral health needs. Providers should share relevant clinical information with appropriate member consent and collaborate on treatment plans when necessary. Additional information on coordination expectations is available in the Provider Orientation materials.

Care Continuity and Coordination Guidelines

PCHP's care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable
- Completing and sending the member's consent for information release to the collaborating provider
- Using the release as necessary for the administration and provision of care
- Noting contacts and collaboration in the member's chart

- Responding to requests for collaboration within 1 week, or immediately if an emergency is indicated
- Sending a copy of a completed Coordination of Care/Treatment Summary Form to us and the member's PCP when the member has seen a behavioral health provider
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's PCP
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan
- Contacting the behavioral health provider when the PCP determines the member's medical condition could reasonably be expected to affect the member's mental health or substance use disorder treatment planning or outcome and documenting the information on the coordination of care and treatment summary

Medical Records Documentation and Referral Information

Behavioral health providers must:

- Utilize the most current DSM multi-axial classification when assessing members
- Document DSM and assessment/outcome information in the member's medical record
- HHSC may require the use of other assessment instruments/outcome measures in addition to the DSM

Additional Behavioral Health Provider Responsibilities

Behavioral health providers must:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment
- Send initial and quarterly summary reports of a member's behavioral health status to the PCP with the member's consent
- Be licensed for physical health services if they are provided

Consent for Disclosure of Information

Providers must:

- Complete and send the member's consent for information release to collaborating providers
- Use the release as necessary for the administration and provision of care
- Note contacts and collaboration in the member's chart

Court-Ordered Commitments

PCHP provides benefits for Medicaid- and CHIP-covered inpatient and outpatient psychiatric services to members from birth through age 20 and ages 65 and over who have been ordered to receive the services by a court of competent jurisdiction, including services ordered under the provisions of the Texas Health and Safety Code, Chapters 5743 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation.

PCHP will:

- Not deny, reduce, or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger or ages 65 and older
- Comply with the utilization review of chemical dependency treatment
- Not allow members ordered to receive treatment under a court-ordered commitment to appeal the commitment through our complaint or appeals processes

Coordination with the Local Mental Health Authority (LMHA) and State Psychiatric Facilities

PCHP's care coordination guidelines include coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable.

Assessment Instruments for Behavioral Health Available for Use by a Primary Care Provider

All providers must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment and referral of behavioral health care services are found on our website at **ParklandHealthPlan.com**.

Focus Studies

PCHP will review prescribing patterns for psychotropic medications. For treatment of adults, parameters will be based on a peer-reviewed industry standard such as the DSHS Psychotropic Drug Formulary. For treatment of children, all providers must utilize the Psychotropic Medication Utilization Parameters for Foster Children.

Utilization Management Reporting Requirements

Providers who furnish routine outpatient behavioral health services must schedule initial appointments within the earlier of 10 business days or 14 calendar days of a request. Routine care after the initial visit must be scheduled within 3 weeks of a request.

Procedures for Follow-up on Missed Appointments

Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Member Discharged from Inpatient Psychiatric Facilities

Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within 7 days from the date of discharge.

Behavioral Health Value-Added Services

PCHP offers online access to resources that help members reduce stress and anxiety and manage depression and substance abuse problems. You will find these tools at **ParklandHealthPlan.com/Members/Resources**.

Emergency and Urgent Behavioral Health Services

Emergency Behavioral Health Services

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

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 9-1-1 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency may occur when the member is:

- Suicidal
- Homicidal
- Violent toward others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug dependent with signs of severe withdrawal

We do not require prior authorization or notification of emergency services, including emergency room and ambulance services.

Urgent Behavioral Health Services

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to him or herself or others and is able to cooperate with treatment. Care for non-life-threatening emergencies should be within six hours.

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

Mental health rehabilitative services and mental health targeted case management must be available to eligible adults who have severe and persistent mental illness and youth who have serious emotional disturbances and who require these services based on the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) assessment.

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
- 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) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking, and feeling.

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

MHR services include training and services that help the member maintain independence in the home and community, such as:

- **Medication training and support**—curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or

her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction, and the increased tenure in the community

- **Psychosocial rehabilitative services**—social, behavioral, and cognitive interventions that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement, and other independent living skills that are affected by or the result of an SMI in persons who are 18 years of age and older
- **Skills training and development**—skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age-appropriate, functioning effectively with family, peers, and teachers
- **Crisis intervention**—intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- **Day program for acute needs**—on-site, short-term intensive treatment group modality to individuals who are18 years of age or older and who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting, or reduce the amount of time spent in the more restrictive setting

Mental health targeted case management (TCM) are services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. Services include:

- Routine or intensive targeted case management for members who have SED (children under 21 years of age)
- Routine targeted case management for members who have SPMI (adults 21 years of age or older)

MHR and TCM, including any limitations to these services, are described in the most current TMPPM, including the Behavioral Health, Rehabilitation and Case Management Services Handbook. Providers of MHR and TCM must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools to assess a member's need for services and must use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must deliver the appropriate amount and intensity of MHR and/or TCM services according to the level of care determined by the ANSA or CANS and as shown in the Texas Resilience and Recovery Utilization Management Guidelines (TRR-UMG). Parkland Community Health Plan (PCHP) is not responsible for reimbursing for any services listed in the TRR-UMG that are not covered services.

Attestation from Provider Entity to MCO

A provider entity must attest to PCHP that the organization has the ability to provide, either directly or through subcontract, the full array of TRR-UMG services to members.

Providers who are qualified and interested in providing Mental Health Rehabilitation and Targeted Case Management services must contact PCHP's provider network team at **PCHP.ContractingDepartment@phhs.org** to initiate the attestation process. The attestation must be completed prior to providers being reimbursed for MHR/TCM services.

HHSC-Established Qualification and Supervisory Protocols

HHSC has established qualifications and supervisory protocols for providers of MHR and targeted case management. These criteria are located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

Resources:

- Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at: **Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health Services**
- Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found at: **TRR Utilization Management Guidelines: Child and Adolescent Services**

Chapter 11: **Member Rights & Responsibilities**

STAR Medicaid Member Rights and Responsibilities

Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider (PCP). 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 PCP.
    b. Choose any health plan you want that is available in your area and choose your PCP from that plan.
    c. Change your PCP.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your PCP.
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. Get a timely answer to your complaint.

c. Use PCHP's appeal process and be told how to use it.

d. Ask for an external medical review and State Fair Hearing from the state Medicaid program and get information about how that process works.

e. Ask for a State Fair Hearing without an external medical review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

b. Get medical care in a timely manner.

c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by PCHP'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 (PCP) quickly.
    c. Make any changes in your health plan and PCP 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 PCP first for your non-emergency medical needs.
    g. Be sure you have approval from your PCP before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
2. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:
    a. Tell your PCP 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.
3. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT services

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

CHIP Member Rights and Responsibilities

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a “limited provider network.” This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses “limited networks,” you should check to see that your child’s primary care provider (PCP) and any specialist doctor you might like to see are part of the same “limited network.”
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's PCP. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for 3 months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her PCP and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment, depending on your income. Copayments do not apply to CHIP Perinate members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with PCHP and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities

1. You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.
2. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
3. You must become involved in the doctor's decisions about your child's treatments.
4. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
5. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
6. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
7. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
8. If your child has CHIP, you are responsible for paying your doctor and other providers' copayments that you owe them. If your child is getting CHIP Perinate services, you will not have any copayments for that child.
9. You must report misuse of CHIP or CHIP Perinate services by health care providers, other members, or health plans.
10. Talk to your child's provider about all of your child's medications.

CHIP Perinate Member Rights and Responsibilities

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.

6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with PCHP and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities

1. You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.
2. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
3. You must become involved in the doctor's decisions about your unborn child's care.
4. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
6. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. You must report misuse of CHIP Perinate services by health care providers, other members, or health plans.
8. Talk to your provider about all of your medications.

Chapter 12: **Complaints & Appeals**

Provider Complaints

PCHP maintains a system for tracking and resolving provider complaints pertaining to administrative issues and nonpayment-related matters within 30 calendar days of receipt. PCHP accepts provider complaints orally through Provider Services at 1-888-672-2277 or in writing.

Written provider complaints should be submitted to:

- **Mail:** Parkland Community Health Plan
  ATTN: Appeals and Complaints
  P.O. Box 560347
  Dallas, TX 75356
- **Fax:** 1-844-310-1823
- **Online:** **PCHP Provider Portal**

When submitting complaint information, we recommend providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications at least until the complaint is resolved.

PCHP will contact the complainant by telephone, email, or in writing within 30 calendar days of receipt of the complaint with the resolution.

At no time will PCHP cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by PCHP, that provider may complain to the state. A complaint to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response from PCHP.

STAR complaints may be sent to:

- Texas Health and Human Services Commissions
  MCCO Research and Resolution
  ATTN: Resolution Services
  P.O. Box 149030, MC: 0210
  Austin, TX 78714-9030

CHIP provider complaints are submitted to TDI, rather than HHSC:

- Texas Department of Insurance
  P.O. Box 149104
  Austin, TX 78714-9104

Provider Claim Appeals

Provider Claim Payment Appeal Procedure

If you disagree with the outcome of a claim, you may utilize PCHP's provider payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment
- Disagreements over reduced or zero-paid claims
- Claim code editing
- Duplicate claim
- Eligibility
- Experimental/investigational procedure
- Claim data
- Timely filing*

*We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Responses to itemized bill requests, submission of corrected claims, and submission of coordination of benefits/third-party liability information are not considered payment appeals. These are considered correspondence and should be addressed to claims correspondence (see the billing and claims administration chapter for more information).

No action is required by the member. Provider payment appeals do not include member medical appeals.

Level I Claim Appeal

The initial PCHP claim appeal is called the Level I claim appeal. This is the first request made by a provider to review and investigate the outcome of a finalized claim.

A Level I claim appeal can be made in writing or online through the **PCHP Provider Portal** within 120 calendar days from the original Explanation of Payment (EOP). Level I claim providers will not be penalized for filing a payment appeal. All information will be confidential.

Claim payment appeals received later than the specified time frame will be considered untimely and upheld unless good cause can be established.

Claim Appeal Submission: When submitting a claim appeal, providers should include as much supporting documentation and information as possible to explain the justification for the appeal.

Examples of appropriate supporting documentation include the following:

- Letter stating the reason(s) why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the PCHP EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (e.g., a copy of ID card, panel report, the TMHP/TexMedNet documentation, call log record with the date and name of the PCHP person the provider's staff spoke with when verifying eligibility)
- Medical records
- Approved authorization forms from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was accepted by PCHP. Note: Rejection reports are not accepted as proof of timely filing.

When submitting a payment appeal, we recommend providers retain all documentation including fax cover pages, email correspondence, and logs of telephone communications at least until the appeal is resolved.

- **Online:** **PCHP Provider Portal**
- **Mail:** Parkland Community Health Plan
  Claims Appeals and Complaints
  P.O. Box 560347
  Dallas, TX 75356-9005

The payment appeals team will research and determine the current status of a payment appeal. A determination will be made based on the available documentation submitted with the appeal and a review of PCHP systems, policies, and contracts. Payment appeals received

with supporting clinical documentation will be retrospectively reviewed by a registered/licensed nurse.

Established clinical criteria will be applied to the payment appeal. After retrospective review, the payment appeal may be approved or forwarded to the plan medical director for further review and resolution.

PCHP will resolve the claim payment appeal within 30 calendar days of receipt. The status of an appeal can be viewed on the **PCHP Provider Portal** or by calling Provider Services. Once an appeal is finalized, a determination letter will be mailed, and a copy will be accessible on the **PCHP Provider Portal**.

The determination letter will include:

- A statement of the provider's appeal request.
- A statement of what action PCHP intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or Provider Manual references.
- An explanation of the provider's right to request a Level II claim appeal within 30 calendar days of the date of the Level I claim appeal determination letter or 120 calendar days from the original EOP if later.
- How to submit a Level II claim appeal.

If the decision results in a claim adjustment, any payment adjustments and the EOP will be sent separately.

Level II Claim Appeal

If you disagree with the outcome of a Level I claim appeal, you may submit a Level II claim appeal.

A Level II claim appeal can be submitted on the **PCHP Provider Portal** or in writing if submitted within 30 calendar days of the date on the Level I claim appeal determination letter.

Claim payment appeals received later than the specified time frame will be considered untimely and upheld unless good cause can be established.

When submitting a Level II claim appeal, the provider should include as much supporting documentation and information as possible to help PCHP understand the reason for disagreement with the Level I claim appeal determination.

PCHP will resolve the claim payment appeal within 30 calendar days of receipt.

The status of an appeal can be viewed on the **PCHP Provider Portal** or by calling Provider Services. Once an appeal is finalized, a determination letter will be mailed, and a copy will be accessible on the **PCHP Provider Portal**.

The determination letter will include:

- A statement of the provider's appeal request.
- A statement of what action PCHP intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or Provider Manual references.

If the decision results in a claim adjustment, any payment and the EOP will be sent separately. PCHP stores all the documentation related to provider appeals in a digital database. This includes retention of fax cover pages, emails to and from PCHP, and a log of telephone communications.

Following the final determination of the Level II claim appeal, the provider has exhausted the PCHP appeal process. For a decision in which the denial was upheld, the provider should review the Participating Provider Agreement for any other available methods of dispute resolution. The provider may also file a complaint with HHSC or TDI as applicable.

Provider Appeal Process through the 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 PCHP.
- The EOB showing the recoupment and/or PCHP's "demand" letter for recoupment. If sending the demand letter, it must identify the client's 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 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 HHSC**
  Claims Administrator Contract Management
  Mail Code-91X
  P.O. Box 204077
  Austin, TX 78720-4077
- **Texas Department of Insurance**
  HMO Quality Assurance Section
  Mail Code 103-6A
  P.O. Box 149104
  Austin, TX 78714-9104

Member Complaint & Appeal Process

STAR Member Complaint Process

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of PCHP's services if it is not related to an Adverse Benefit Determination. A complaint related to an Advanced Benefit Determination is considered an appeal, which is covered later in this chapter.

PCHP provides a designated Member Advocate to assist members in understanding our complaint process. The Member Advocate assists members in writing or filing a complaint and monitor the complaint process until the issue is resolved

What should a member do if they have a complaint?

- A member can tell us about their complaint by calling us at 1-888-672-2277 (TTY 7-1-1) or writing us at
- **Email:** PCHPComplaintsandAppeals@phhs.org
- **Mail:** Parkland Community Health Plan
  ATTN: Member Advocate
  P.O. Box 560347
  Dallas, TX 75356

How long will it take to process a complaint?

We will send the member a letter within 5 business days of getting the complaint. This means that we have their complaint and have started to look at it. We may call them to get more information. We will send them a letter within 30 days of when we get the complaint. This letter will explain what we have done to address the complaint.

How do members file a complaint with the Health and Human Services Commission once they have gone through the PCHP complaint process?

Once you have gone through the PCHP complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

- Texas Health and Human Services Commission
  Ombudsman Managed Care Assistance Team
  P.O. Box 13247
  Austin, Texas 78711-3247

If you have internet access, you can submit your complaint at: **hhs.texas.gov/managed-care-help**.

If a member files a complaint, PCHP will not hold it against them. We will still be here to help them get quality health care.

Do members have the right to make a complaint appeal?

Yes. If they're not happy with the answer to their complaint, they can ask us to look at it again. They must ask for a complaint appeal in writing. members can write to us at:

- **Email:** **PCHPComplaintsandAppeals@phhs.org**
- **Mail:** Parkland Community Health Plan
  ATTN: Member Advocate
  P.O. Box 560347
  Dallas, TX 75356

When we get the request, we'll send the member a letter within 5 business days. This means that we have the request and have started to work on it. They can also call us at 1-888-672-2277 (TTY 7-1-1) to ask for a complaint appeal. We'll send them a letter within 30 days of getting the request. The letter will explain the complaint appeal decision. This letter will also give the member the information PCHP used to make its decision.

STAR Member Appeal Process

What can I do if the MCO denies or limits my member's request for a covered service?

There may be times when PCHP says we will not pay for or cover all or part of the care that has been recommended. Members have the right to ask for an appeal.

Members can appeal the decision by:

- Calling Member Services.

- Sending a letter to:
  Parkland Community Health Plan
  ATTN: Complaints and Appeals
  P.O. Box 560347
  Dallas, TX 75356

The member can have someone else help them with the appeal process. This person can be a family member, friend, their doctor, or another person.

How will I find out if services are denied?

If we deny services, we will notify the member or members LAR and the member's provider of our determination. A notice of action (NOA) determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension, or termination of a previously authorized service.

What are the time frames for the appeal process?

PCHP must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for appeal, including the option to extend up to 14 days if member requests an extension; or if PCHP shows that there is a need for additional information and how the delay is in the member's interest. If PCHP needs to extend, member must receive written notice of the reason for the delay.

When does a member have the right to ask for an appeal?

The member must request an appeal within 60 days from the date on the first letter from PCHP that says we will not pay all of part of the service.

Appeals are accepted orally or in writing. Within 5 working days from receipt of the written or verbal appeal, PCHP will send an acknowledgement letter.

The services being received by the member, including the benefit that is the subject of the appeal, will be continued if all the following criteria are met:

- The member or member's LAR, including the member's physician or health care provider with written consent from the member files the appeal timely as defined in the contract.
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or LAR request continuation of benefits before the later of:

- 10 days following PCHP's mailing of the notice of action, or the intended effective date of the proposed action
- If, at the member's request, PCHP continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  - The member withdraws the appeal.
  - 10 days pass after PCHP mails the notice, providing resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State Fair Hearing.
  - A State Fair Hearing Officer issues a hearing decision adverse to the member.

The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

Can someone from PCHP help a member file an appeal?

The member or members LAR can contact Member Services Medicaid: 1-888-672-2277 (TTY: 7-1-1). A Member Advocate is also available to assist the member in filing an Appeal.

What if the member disagrees with the appeal resolution?

The member or the member's LAR has the option of requesting a State Fair Hearing and an external medical review at the same time. The member must ask for the State Fair Hearing and external medical review within 120 days of the date on the PCHP letter that tells of the decision being challenged.

Or the member or member's LAR has the option of requesting only a State Fair Hearing no later than 120 days of the date of the PCHP appeal decision notice. At any time during or after the PCHP appeals process.

Expedited (Emergency) Medical Appeal

A member may request an expedited (emergency) medical appeal verbally or in writing in cases where time expended in the standard resolution could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. An expedited (emergency) medical appeal concerns a decision or action by PCHP that relates to:

- Health care services including, but not limited to, procedures or treatments for a member with an ongoing course of treatments ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life

- A treatment referral, service, procedure, or other health care service that if denied could significantly increase risk to a member's health or life

What is an expedited (emergency) appeal?

An expedited (emergency) appeal is when PCHP has to make a decision quickly based on the condition of the member's health and taking the time for a standard appeal could jeopardize their life or health.

How does a member ask for an expedited emergency appeal? Does the request have to be in writing?

The member or the person they ask to file an appeal for them can request an expedited appeal. orally or in writing:

- **Phone:** 1-888-672-2277 (STAR); 1-888-814-2352 (CHIP) (TTY: 7-1-1)
- **Mail to:** Parkland Community Health Plan
  ATTN: Complaints and Appeals
  P.O. Box 560347 Dallas, TX 75356

What are the time frames for an expedited (emergency) appeal?

After PCHP gets the member's letter or call and agrees their request for an appeal should be expedited, we will send them a letter with the answer to their appeal. We will do this within 72 hours from receipt of the appeal request.

If the member's appeal is about an ongoing emergency or hospital stay, we will call them with our decision within 1 business day from the receipt of their appeal request. We will also send them a letter with the answer to their appeal within 3 business days.

What happens if PCHP denies the request for an expedited (emergency) appeal?

If we do not agree that a member's request for an appeal should be expedited, we will call them right away. We will send them a letter within 2 calendar days to let them know how the decision was made and that their appeal will be reviewed through the standard review process.

Who can help a member file an expedited (emergency) appeal?

A Member Advocate or Member Services Representative can help a member file an expedited (emergency) appeal. Call Member Services at 1-888-672-2277 (STAR) or 1-888-814-2352 (CHIP) (TTY: 7-1-1).

Can a member ask for a state fair hearing?

If a member, as a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The member may name someone to

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

- **Mail:** Parkland Community Health Plan
  ATTN: State Fair Hearing
  P.O. Box 560347 Dallas, TX 75356
  Phone: 1-888-672-2277

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.

Can a member ask for an external medical review?

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

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to PCHP by using the address or fax number at the top of the form.;
- Call PCHP at 1-888-672-2277.
- Email PCHP at **PCHPComplaintsandAppeals@phhs.org** or;

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

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

Once the external medical review decision is received, the member has the right to withdraw the State Fair Hearing request. 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, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency external medical review?

If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency external medical review and emergency State Fair Hearing by writing or calling PCHP. To qualify for an emergency external medical review and emergency State Fair Hearing the member must first complete PCHP's internal appeals process.

CHIP Member Complaint Process

What should a member do if they have a complaint?

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of PCHP's services if it is not related to an adverse determination. A complaint related to an advanced determination is considered an appeal, which is covered later in this chapter.

PCHP provides a designated Member Advocate to assist members in understanding our complaint process. The Member Advocate assists members in writing or filing a complaint and monitor the complaint process until the issue is resolved

Who do I call? Can someone from PCHP help a member file a complaint?

A PCHP Member Advocate or a Member Services Representative can help file a complaint with PCHP or the appropriate state program. Please call Member Services at 1-888-814-2352 (TTY: 7-1-1) or writing us at:

- **Email:** PCHPComplaintsandAppeals@phhs.org
- **Mail:** Parkland Community Health Plan
  ATTN: Member Advocate
  P.O. Box 560347 Dallas, TX 75356

How long will it take to process a member's complaint?

We will send the member a letter within 5 business days of getting the complaint. This means that we have their complaint and have started to look at it. We may call them to get more information. We will send them a letter within 30 days of when we get the complaint. This letter will explain what we have done to address the complaint

If a member is not satisfied with the outcome, who else can they contact?

If a member is not satisfied with the answer to their complaint, they can also complain to the Texas Department of Insurance by calling toll-free 1-800-252-3439.

If they would like to make their request in writing, they can send it to:

- **Mail:** Texas Department of Insurance Consumer Protection
  PO Box 149091
  Austin, TX 78714-9091
- **Email:** tdi.texas.gov/consumer/complfrm.html

Does a member have the right to make a complaint appeal?

Yes. If a member is not happy with the answer to their complaint, they can ask us to look at it again. They must ask for a complaint appeal panel in writing.

- **Email: PCHPComplaintsandAppeals@phhs.org**
- **Mail to:** Parkland Community Health Plan
  ATTN: Complaints and Appeals
  P.O. Box 560347
  Dallas, TX 75356

When we get the request, we'll send the member a letter within 5 business days. This means that we have their request and have started to work on it. They can also call us at 1-888-814-2352 (TTY: 7-1-1) to ask for a complaint appeal.

We'll have a meeting with PCHP staff, providers in the health plan, and other PCHP members to look at the complaint.

We'll send the member a letter within 30 days of getting their written request. The letter will tell them the complaint appeal decision. This letter will also give them the information used to make the decision.

CHIP Member Appeal Process

What can I do if the MCO denies or limits my member's request for a covered service?

There may be times when PCHP says we will not pay for or cover all or part of the care that has been recommended. Members have the right to ask for an appeal.

Members can appeal the decision by:

- Calling Member Services.
- Sending a letter to:
  Parkland Community Health Plan
  ATTN: Complaints and Appeals
  P.O. Box 560347
  Dallas, TX 75356

The member can have someone else help them with the appeal process. This person can be a family member, friend, their doctor, or another person.

How will I find out if services are denied?

If we deny services, we will notify the member or members LAR and the member's provider of our determination. A notice of action (NOA) determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension, or termination of a previously authorized service.

What are the time frames for the appeal process?

PCHP must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for appeal, including the option to extend up to 14 Days if member requests an extension; or if PCHP shows that there is a need for additional information and how the delay is in the member's interest. If PCHP needs to extend, member must receive written notice of the reason for the delay.

How will I find out if the Appeal is denied?

If we deny an appeal request a response will be provided in writing including the rationale for the decision and the guidelines utilized in this review.

What are the time frames for the appeal process?

Within 5 working days from receipt of the written or verbal appeal, PCHP will send an acknowledgement letter. PCHP must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for appeal, including the option to extend up to 14 days if member requests an extension; or if PCHP shows that there is a need for additional information and how the delay is in the member's interest. If PCHP needs to extend, Member must receive written notice of the reason for the delay.

When does a member have the right to ask for an appeal?

The member must request an appeal within 60 days from the date on the first letter from PCHP that says we will not pay all of part of the service. Appeals are accepted orally or in writing.

Can someone from PCHP help a member file an appeal?

The member or members LAR can contact Member Services Medicaid: 1-888-814-2352 (TTY: 7-1-1). A Member Advocate is also available to assist the member in filing an Appeal.

Member Expedited MCO Appeal

An expedited medical appeal will be performed when appropriate. A member may request an expedited medical appeal in cases where time expended in the standard resolution could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. An expedited medical appeal concerns a decision or action by PCHP that relates to:

- Health care services including, but not limited to, procedures or treatments for a member with an ongoing course of treatments ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life
- A treatment referral, service, procedure, or other health care service that if denied could significantly increase risk to a member's health or life

How does a member ask for an expedited emergency appeal? Does the request have to be in writing?

The member or the person they ask to file an appeal for them can request an expedited appeal. orally or in writing:

- **Phone:** 1-888-814-2352 (CHIP) (TTY: 7-1-1)
- **Mail to:** Parkland Community Health Plan
  ATTN: Complaints and Appeals
  P.O. Box 560347
  Dallas, TX 75356

What are the time frames for an expedited (emergency) appeal?

After we get the member's letter or call and agree their request for an appeal should be expedited, we will tell call them with our decision within 1 business day from receipt of their appeal request. We will let them know by phone or electronically, and a written notice will also be sent within 3 business days.

What happens if PCHP denies the request for an expedited (emergency) appeal?

If we do not agree that a member's request for an appeal should be expedited, we will call them right away. We will send them a letter within 2 calendar days to let them know how the decision was made and that their appeal will be reviewed through the standard review process.

Who can help a member file an expedited appeal?

A Member Advocate or Member Services Representative can help a member file an expedited (emergency) appeal. Call Member Services at 1-888-814-2352 (CHIP) (TTY: 7-1-1).

If the child has a life-threatening condition or we deny prescription drugs or intravenous infusions that are already being received, the member, someone acting on their behalf, or the provider can ask for an immediate review by an Independent Review Organization. The member does not have to go through the PCHP internal appeal process first.

Member Independent Review Organization Process

What is an Independent Review Organization?

An Independent Review Organization (IRO) is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

Maximus Federal Services, Inc. is the Independent Review Organization that will conduct an external review when requested.

How can members request an external review by an Independent Review Organization?

A member can ask for an IRO review by filling out the "Request for a Review by an Independent Review Organization" form that is sent with the decision letter. Complete, sign, and return the HHS-Administered Federal External Review Request Form to MAXIMUS Federal Services to

request an external review. Please note that a release of medical information to MAXIMUS Federal Services is included as part of the request form. It must be signed by the member or the member's legal guardian. Mail or fax the form along with the Adverse Determination notice received directly to:

- MAXIMUS Federal Services
  3750 Monroe Avenue, Suite 705
  Pittsford, NY 14534
- **Phone:** 1-888-866-6205 (toll-free)
- **Fax:** 1-888-866-6190

The member can also submit the external review request online at externalappeal.com under the "Request a Review Online" link in the heading. If the member has any questions or concerns before or during the external review process, they can call MAXIMUS at the above number. The member can submit additional written comments to the external reviewer at the MAXIMUS mailing address above. If any additional information is submitted, it will be shared with Parkland Community Health Plan to give us an opportunity to reconsider the denial.

A member can ask for an expedited external review:

- If they asked for an expedited appeal after their initial denial and waiting up to 72 hours would seriously jeopardize their life, health, or ability to regain maximum function, they can request an expedited external review at the same time
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize their life, health, or ability to regain maximum function
- If the appeal decision is about an admission, availability of care, continued stay, or health- care service for which emergency services were received but the member has not been discharged from the facility

How to request an expedited external review

- **Online:** Select "expedited" when submitting the review request, or
- **Email:** **FERP@maximus.com** or
- **Call:** Federal External Review Process at 1-888-866-6205 ext. 3326

If a member files an appeal or asks for an external review, we will not hold it against them or their provider.

CHIP members must complete the first level of the PCHP appeal process resulting in an adverse decision prior to filing a request for a review by an Independent Review Organization (IRO), except in the case of a life-threatening condition or a denial for prescription drugs or intravenous infusions already being received. The member (or person acting on behalf of the member) can request an IRO hearing by submitting the IRO form attached to the appeal letter to:

- **Mail:** Parkland Community Health Plan
  ATTN: Member Advocate IRO Appeals
  P.O. Box 560347 Dallas, TX 75356

What are the timeframes for this process?

Standard External Review: MAXIMUS will provide a decision as soon as possible, but no later than 45 calendar days of receiving the request.

Expedited External Review: MAXIMUS will provide a decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

Chapter 13: **Quality Management**

PCHP Quality Management Program

Overview

PCHP maintains a comprehensive Quality Management (QM) program to objectively monitor and systematically evaluate the care and service provided to members. Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results.

The Quality Improvement Program is tailored to membership needs in terms of age groups, disease categories, and special risk status. The program is developed based on population needs and undergoes annual re-evaluation, including risk stratification, analysis of utilization data to identify high-volume areas and preventable events.

PCHP maintains a quality committee structure including a Quality Improvement Committee (QIC), Provider Advisory Committee (PAC), Utilization Care Management Committee, Member Advisory Committee, Quality of Service Committee, and Credentialing Committee with participation from network physicians and practitioners or members.

Note: All providers must allow PCHP to use performance data in cooperation with our Quality Improvement program and activities.

Quality Improvement Committee

The Quality Improvement Committee (QIC) serves as the central oversight body for PCHP's quality initiatives. Comprising interdepartmental staff and network providers, the QIC directs the Medicaid Quality Management program while maintaining quality as a cornerstone of PCHP's culture.

The QIC's comprehensive responsibilities include:

- Strategic implementation and oversight of the QAPI Plan
- Review and approval of quality-related policies and reports
- Submission of required regulatory reporting
- Direction of performance improvement activities and clinical studies
- Evaluation of HEDIS metrics and satisfaction survey results
- Assessment of care continuity between medical and behavioral health
- Identification of improvement opportunities and follow-up actions
- Ensuring member and provider input into quality activities

- Promoting interdepartmental collaboration on quality initiatives
- Ensuring compliance with state, federal, and accreditation standards

The committee serves as an instrument of change through demonstrable improvement in care and service, regularly evaluating the program's effectiveness and adequacy of resources.

Provider Advisory Committee (PAC)

The PAC assesses care quality and recommends standards. It serves as a collaborative forum for healthcare providers to offer insights, recommendations, and feedback on health plan policies, procedures, and quality initiatives and provides oversight of the Quality Management program. Responsibilities include:

- Monitoring practice patterns for appropriateness
- Reviewing and approving evidence-based clinical practice guidelines and protocols
- Evaluating clinical studies and new technologies
- Collecting provider feedback for improvement efforts
- Providing regulatory updates to providers
- Sharing best practices with providers

Credentialing Committee

This committee credentials and recredentials participating all participating providers according to plan, state, and federal accreditation standards. Responsibilities include:

- Conducting reviews for all providers who apply for participation in the network
- Reviewing all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports
- Approving or denying providers submitted by a delegated credentialing entity
- Updating credentialing policies
- Reporting physician actions and sanctions imposed based upon recredentialing activity to the QIC
- Approving or denying providers for participation in the network and report decisions to the QIC
- Reviewing and evaluating all oversight monitoring activities and results on an annual basis (e.g., quarterly report results, annual audit results, and other oversight activities as applicable).
- Evaluating and reporting the effectiveness of the credentialing program (e.g., timeliness, volume, percentage of clean files, percentage of complaints) to the QIC

Peer review aspects of the credentialing committee

- The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:
- To participate in the implementation of the established peer review system
- To review and make recommendations regarding individual provider peer review cases
- To work in accordance with the executive medical director
- Should investigation of a member complaint result in concern(s) regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed. Dissatisfaction severity codes and levels of severity are applied to quality issues.

The medical director assigns a level of severity to the complaint. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the QIC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions, and/or disciplinary actions to be taken.

Outcomes are reported to the appropriate internal and external entities, which include the QIC. The peer review process is a major component of the QIC monthly agenda. The peer review policy is available upon request.

Clinical Practice Guidelines

PCHP shares with providers clinical guidelines developed using nationally recognized, evidence-based standards. Guidelines summarize management options for specific conditions based on scientific consensus from recognized sources.

Clinical practice guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

Practice guidelines are shared nationally and adopted locally through Provider Advisory Committees that include practicing physicians who participate in PCHP. This group also suggests topics for guideline selection based on relevance to enrolled membership, identifying high-volume, high-risk, problem-prone conditions as the priority.

Practice guidelines are shared nationally and adopted locally through Provider Advisory Committees that include practicing physicians who participate in PCHP. This group also suggests topics for guideline selection based on relevance to enrolled membership,

identifying high-volume, high-risk, problem-prone conditions as the priority. The guidelines must be reviewed and revised at least every 2 years or whenever the guidelines change.

PCHP has adopted a wide range of clinical practice guidelines. We select evidence-based guidelines that are relevant to the member population.

Visit PCHP's website for the most up to date list of adopted guidelines at **Providers.ParklandHealthPlan.com/Resources/PCHP-Information**.

Focus Studies and Performance Improvement Projects

PCHP's Quality Management team is involved in conducting clinical and service utilization studies along with HHSC required performance improvement projects (PIPs) that may or may not require medical record review or additional information from our participating providers. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

HEDIS® Reporting Data Collection

Quality Management will be coordinating the annual HEDIS® project collecting administrative (claims) data and conducting chart medical record review to abstract data from providers' charts that show demonstration of services received by members according to HEDIS® specifications. Provider participation is critical to successful data collection with each annual project.

Focus Studies

We are required to conduct at least two focus studies per year based on state requirements. PCHP utilizes national standards to create focus studies for clinical and non-clinical services, cost and utilization, and effectiveness of care. Each year PCHP evaluates the effectiveness of its Quality Improvement program based on the National Committee for Quality Assurance (NCQA) standards for service and quality of care.

Utilization Management Reporting Requirements

The primary responsibility for monitoring appropriate use of health services is vested with PCHP's medical director. The medical director will establish utilization management requirements that may be revised from time to time to assure the delivery of quality care in a cost-effective manner. The medical director will be assisted by the quality director who will act on behalf of the medical director in communicating with participating providers.

New Technology

Our medical director and participating providers review and evaluate new medical advances in technology or the new application of existing technology in medical procedures, behavioral

health procedures, pharmaceuticals, and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed to determine if the treatment is safe and effective. The new medical advance or treatment or new application of existing technology must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by PCHP.

Appendix A: **Community First Choice**

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation). 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 acting on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if

transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.

- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.