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Introduction
Dell Children’s Health Plan is a health plan for the Children’s Health Insurance Program (CHIP) and State of Texas Access Reform (STAR) members in the Travis Service Area. Dell Children’s Health Plan has been an administrator of CHIP since 2000 and was selected to administer the CHIP Perinatal and STAR programs in Central Texas beginning March 1, 2012.

Program Objectives
Dell Children’s Health Plan provides health care to its members through a network of physicians, hospitals and other health care professionals. We are a licensed Texas managed care organization dedicated to providing quality care to our members and offering information to assist providers in treating their patients. Our goal at Dell Children’s Health Plan is to keep the families enrolled in our health plan healthy and to make sure that these members receive the proper treatment if they become sick or injured.

Dell Children’s Health Plan members are required choose a PCP. PCPs coordinate our members’ health care services, including preventive care, and refer members to specialists and other health care providers as needed.

Dell Children’s Health Plan retains the right to add to, delete from and otherwise modify this provider manual. Material in this provider manual is subject to change. Please visit dellchildrenshealthplan.com/providers or the most up-to-date information.
## CHAPTER 2: QUICK REFERENCE PHONE LIST

<table>
<thead>
<tr>
<th></th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>1-888-596-0268 (TTY 711)</td>
</tr>
<tr>
<td>Provider Services</td>
<td>1-888-821-1108</td>
</tr>
<tr>
<td>(Claims status, eligibility and benefits)</td>
<td></td>
</tr>
<tr>
<td>Provider Relations Department</td>
<td>512-324-3125</td>
</tr>
<tr>
<td>Utilization Management Department</td>
<td>1-888-821-1108</td>
</tr>
<tr>
<td>Disease Management Department</td>
<td>1-888-830-4300</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>1-888-821-1108</td>
</tr>
<tr>
<td>Superior Vision of Texas</td>
<td>1-800-879-6901 (for providers and members)</td>
</tr>
<tr>
<td>Navitus (Pharmacy Benefit Manager)</td>
<td>1-877-908-6023</td>
</tr>
<tr>
<td>HHSC Dental Contractors</td>
<td>DentaQuest (CHIP): 1-800-508-6775</td>
</tr>
<tr>
<td></td>
<td>DentaQuest (Medicaid): 1-800-516-0165</td>
</tr>
<tr>
<td></td>
<td>MCNA Dental: 1-800-494-6262</td>
</tr>
</tbody>
</table>
CHAPTER 3: PROVIDER ROLES

Role of the Primary Care Provider or Medical Home
The PCP serves as the medical home and is responsible for all provisions of primary care, including preventive health services, in accordance with the STAR/CHIP programs. In addition, 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.

Role of the Specialty Care Provider
Dell Children’s Health Plan has established a network of specialty care providers to provide health care services for those members in need of specialty care. Network referrals from the PCP are not required for the majority of specialties (For more information on prior authorization, refer to the Utilization Management chapter in this manual and the preauthorization lookup tool on our provider website at dellchildrenshealthplan.com/providers.

The specialty care provider coordinates care with the member’s PCP and is responsible for obtaining precertification 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 nurse case managers are available to assist specialty providers with the management of the catastrophic, chronic or problem cases.

Role of the CHIP Perinatal Provider
CHIP Perinatal Program benefits are limited to services that affect the health of the unborn child. Expectant mothers enrolled in the CHIP Perinatal program will not have an assigned PCP on their ID. CHIP Perinatal members (pregnant women) can go to any CHIP Perinatal provider listed on the Dell Children’s Health Plan provider list for prenatal and postpartum care.

Role of the Pharmacy
All members have access to pharmacy services. Dell Children’s Health Plan has an arrangement with Navitus Health Solutions to administer pharmacy benefits for Dell Children’s Health Plan CHIP and STAR members. Navitus is contracted with pharmacies that serve CHIP and STAR managed care members. Dell Children’s Health Plan 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 www.txvendordrug.com. Dell Children’s Health Plan and Navitus network providers can also access the formulary and PDL at this site.

Role of the Main Dental Home
Dental plan members may choose their main dental homes. Dental plans will assign each member to a main dental home if he/she does not timely choose one. Whether chosen or assigned, each member who is 6 months or older must have a designated main dental home.

Federally qualified health centers and individuals who are general dentists and pediatric dentists can serve as main dental homes. A main dental home serves as the member’s main dentist for all aspects of
oral health care and should have 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.

**Network Limitations**
Members are limited to the use of Dell Children’s Health Plan-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 (nonurgent) out-of-network referrals require prior authorization and are reviewed and approved by the Dell Children’s Health Plan medical director or designee. Referral prior authorization is not required for the majority of in-network specialty care physicians; see the prior authorization grid for more information.
CHAPTER 4: STAR COVERED SERVICES

Texas Health Steps Services- STAR (Medicaid) Members Only

Texas Health Steps is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under Texas Health Steps, medical and dental preventive care and dental treatment services are available through Medicaid providers to Medicaid-enrolled children from birth through age 20. The program provides payment for comprehensive, periodic evaluations of a child’s health, development and nutritional status, including vision, hearing, dental and case management services. For information regarding Texas Health Steps requirements, providers can refer to the resources listed below:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Health Steps website</td>
<td><a href="http://www.dshs.state.tx.us/thsteps/default.shtm">www.dshs.state.tx.us/thsteps/default.shtm</a></td>
</tr>
</tbody>
</table>

Information includes:

- Periodicity schedule
- State and federally mandated elements of the Texas Health Steps 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
- ImnTrac (immunization registry)
- Submission of all laboratory specimens (collected as a required component of a Texas Health Steps 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

Texas Health Steps medical providers (participating and nonparticipating) may perform Texas Health Steps medical checkups on any Dell Children’s Health Plan member, regardless of panel assignment. Claims for these services should be submitted to us. Please fax or mail a copy of the Texas Health Steps record to the member’s primary care provider. Texas Health Steps network providers are reimbursed according to their contracts with us. Nonparticipating providers will be paid in accordance with the state’s out-of-network rules.

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. 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 Texas Health Steps 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 Texas Health Steps annual medical checkup for an existing member 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, based on the member’s birth date. If a member misses a Texas Health Steps 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.

Children of Migrant Farmworkers

Children of migrant farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup. Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

Contact our Provider Relations department at 512-324-3125 to report any health plan members that you identify as children of migrant farmworkers.

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.

Nonemergent
Nonemergency 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 website at dellchildrenshealthplan.com/providers, 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 nonemergent ambulance transportation.

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 nonemergent 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. The request can be called in or faxed the next business day to the numbers listed in the table below.

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Behavioral Health (BH) facilities or to a BH provider</th>
<th>All other members for discharge from facility to home or from home to a provider/facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent same day</td>
<td>Call 1-800-325-0011, ext. 35933, Option 2.</td>
<td>Call 1-800-325-0011, ext. 35760.</td>
</tr>
<tr>
<td>Nonurgent requests</td>
<td>Fax request to 1-866-877-5229.</td>
<td>Fax request to 1-866-249-1271.</td>
</tr>
</tbody>
</table>

**Medical Transportation Program**

Medicaid members are eligible for the Medical Transportation Program (MTP), a free service provided through the Texas Department of Health and Human Services. The service provides transportation to appointments with doctors, dentists, pharmacies or other health care service providers.

To obtain a ride, members or their authorized representatives should call MTP at 1-877-633-8747:
- At least two working days or more before needing a ride
- At least five working days or more before requiring out-of-town or long-distance travel
- If same- or next-day service is needed (MTP will try to help, but a ride is not guaranteed)

When calling MTP, please furnish:
- The member’s nine-digit Medicaid identification number or Social Security number
- The name, address and telephone number of the member needing the ride
- The member’s pickup address
- The date and time of the health care appointment
- What type of transportation services are needed
- Notification of the member’s special needs (for example, accessible transportation if the member is disabled)

If a Dell Children’s Health Plan member is unable to obtain transportation through MTP, he or she should contact Member Services at 1-888-596-0268 (TTY 711). Dell Children’s Health Plan includes additional transportation benefits in the value-added services available to members. A description of these benefits can be found in the member handbooks available at dellchildrenshealthplan.com/providers.
**Dental Services**

Dell Children’s Health Plan STAR members age 20 and younger are covered for dental services through their core Medicaid benefits. Members select a dental maintenance organization though HHSC’s enrollment broker to provide these services.

**Nonemergency Dental Services**

Dell Children’s Health Plan is **not responsible** for paying for routine dental services provided to Medicaid members. These services are paid through dental managed care organizations (MCOs). Dell Children’s Health Plan is **responsible** for paying for:

- Treatment and devices for craniofacial anomalies
- Oral evaluation and fluoride varnish benefits (OEFV), provided as part of a Texas Health Steps medical checkup (for members aged 6 through 35 months)

Medical providers for Texas Health Steps must complete training and become certified to provide the intermediate oral evaluation and fluoride varnish application before providing these services. 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 [www.txhealthsteps.com](http://www.txhealthsteps.com).

During a visit, the OEFV benefit includes intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance and assistance with a main dental home choice. Some important notes to remember about the OEFV benefit:

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup (99381, 99382, 99391, or 99392 medical checkup procedure code).
- OEFV must be billed concurrently with a Texas Health Steps 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.
- Texas Health Steps 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 federally qualified health centers. For more information, see [www.dshs.state.tx.us/dental/OEFV.shtm](http://www.dshs.state.tx.us/dental/OEFV.shtm).

**CHIP Nonemergency Dental Services**

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

**Medicaid Emergency Dental Services**

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

- Treatment of a dislocated jaw/traumatic damage to teeth
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
CHIP Emergency Dental Services
Dell Children’s Health Plan is responsible for emergency dental services provided to CHIP members and CHIP Perinatal 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

Vision Services
Coverage for STAR members may be obtained by calling Superior Vision of Texas at 1-800-879-6901. Services are available for member self-referral to a network vision provider for basic vision benefits. Members can call 1-800-879-6901.

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefits</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR members age 20 and younger</td>
<td>One eye exam and medically necessary lenses and frames or contacts once every state fiscal year (September 1 through August 31)</td>
<td>Coverage may be obtained by calling Superior Vision of Texas at 1-800-879-6901 (for providers and members).</td>
</tr>
<tr>
<td>STAR adult members (age 21 and older)</td>
<td>Available for adult members age 21 and older, including one eye exam and medically necessary lenses, frames or contacts once every two state fiscal years (September 1 through August 31)</td>
<td>Coverage may be obtained by calling Superior Vision of Texas at 1-800-879-6901 (for providers and members).</td>
</tr>
</tbody>
</table>

STAR (Medicaid) Managed Care Covered Services
Dell Children’s Health Plan 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 for a listing of limitations and exclusions at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Covered benefits include, but are not limited to, the medically necessary services below:
- Ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral health services*, including:
  - Inpatient mental health services for adults and children (services may be provided in a freestanding psychiatric hospital in lieu of an acute care inpatient setting)
  - Outpatient mental health services
  - Psychiatry services
  - Mental health rehabilitative services
  - Counseling services for adults (21 years of age and over)
  - Outpatient substance use disorder treatment services including:
    - Assessment
    - Detoxification services
    - Counseling treatment

* These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the MCO’s nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.
Medication-assisted therapy

Residential substance use disorder treatment services including:
- Detoxification services
- Substance use disorder treatment (including room and board)

- Birthing services provided by a 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
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction and related follow-up procedures, including inpatient and outpatient services provided 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; and
  - 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 Texas Health Steps Program
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Primary care services
- Preventive services, including an annual adult well check for patients 21 years of age and over
- Radiology, imaging and X-rays
- Specialty physician services
- Telehealth
- Telemonitoring to the extent covered by Texas Government Code §531.01276
- Therapies (physical, occupational and speech)
- Transplantation of organs and tissues
- Vision (Note: Includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
Overview
There are other services not covered through Dell Children’s Health Plan; however, the services are available to STAR members through other state programs. Dell Children’s Health Plan providers should make every effort to coordinate with these resources in order to maximize the STAR member’s benefits.

Providers must coordinate with Texas Agency Administered Programs, Case Management Services and Essential Health Services. Additional details and information on the Texas Health Steps program are available to providers in the Texas Medicaid Provider Procedures Manual (TMPPM). These services include:

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early childhood intervention (ECI) case management/service coordination
- Early childhood intervention specialized skills training
- Case management for children and pregnant women
- Texas school, health and related services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Health and Human Services Commission’s Medical Transportation Program (refer to the Medical Transportation Program section for more information)
- Court-ordered commitments to inpatient mental health facilities as a condition of probation
- Texas Health Steps personal care services for members birth through age 20
- Community First Choice (CFC) services

All participating providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Provider Services at 1-888-821-1108.
CHAPTER 6: CHIP AND CHIP PERINATAL COVERED SERVICES

CHIP Covered Services
Covered CHIP services must meet the CHIP definition of medically necessary covered services. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Copays apply until a family reaches its specific cost-sharing maximum.

CHIP Perinatal Covered Services
Covered CHIP Perinatal services must meet the definition of medically necessary covered services. There is no lifetime maximum on benefits; however, 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. CHIP Perinate newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment as a CHIP Perinatal member.

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<tr>
<th>Covered Benefit</th>
<th>CHIP and CHIP Perinatal Newborn Members</th>
<th>CHIP Perinatal Members (Unborn Child)</th>
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</thead>
</table>
| Inpatient General Acute and Inpatient Rehabilitation Hospital Services | Services include but are not limited to:  
- 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  
- Intensive care unit (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, |  
- CHIP Perinate (unborn child) 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 will receive 12 months of continuous Medicaid coverage (effective on the date of birth), after the birth is reported to HHSC’s enrollment broker.  
- A CHIP Perinate mother in a family with income at or below the Medicaid eligibility threshold may be eligible to have the cost 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.  
- 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.  |
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</table>
| EKGs, etc.      | • Oxygen services and inhalation therapy  
|                 | • Radiation and chemotherapy          | • Services include:               |
|                 | • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care  
|                 | • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section  
|                 | • Hospital, physician and related medical services, such as anesthesia, associated with dental care  
|                 | • Inpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or nonviable 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  
|                 | • Surgical implants  
|                 |   o 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 External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have  
|                 | • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).  
|                 | • Inpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. These services 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  

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<td></td>
<td>been performed</td>
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<td></td>
<td>o Surgery and reconstruction on the other breast to produce symmetrical appearance</td>
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<td></td>
<td>o Treatment of physical complications from the mastectomy and treatment of lymphedemases</td>
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<td></td>
<td>• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit.</td>
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<td></td>
<td>• 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:</td>
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<td></td>
<td>o cleft lip and/or palate; or</td>
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<td></td>
<td>o severe traumatic skeletal and/or congenital craniofacial deviations</td>
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<td></td>
<td>o Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment</td>
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<tr>
<td>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</td>
<td>Services include but are not limited to:</td>
<td>Not a covered benefit.</td>
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<td></td>
<td>• Semi-private room and board</td>
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<td></td>
<td>• Regular nursing services</td>
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<td></td>
<td>• Rehabilitation services</td>
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<td></td>
<td>• Medical supplies and use of appliances and equipment furnished by the facility</td>
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<td>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and</td>
<td>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:</td>
<td>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:</td>
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<tr>
<td></td>
<td>• X-ray, imaging and radiological tests (technical component)</td>
<td>• X-ray, imaging and radiological tests (technical component)</td>
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<td></td>
<td>• Laboratory and pathology services</td>
<td>• Laboratory and pathology services (technical component)</td>
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<td>Covered Benefit</td>
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</table>
| Ambulatory Health Care Center | (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints and dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or nonviable 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 • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants o 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: | • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or nonviable 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 Notes: • Laboratory and radiological services are limited to services that directly relate to ante-partum care and/or the delivery of the covered CHIP Perinatal member until birth. • Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or nonviable pregnancy. • Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. • Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody...
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<th>Covered Benefit</th>
<th>CHIP and CHIP Perinatal Newborn Members</th>
<th>CHIP Perinatal Members (Unborn Child)</th>
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<td></td>
<td>o All stages of reconstruction on the affected breast</td>
<td>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.</td>
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<td></td>
<td>o External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed</td>
<td>• Surgical services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.</td>
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<td></td>
<td>o Surgery and reconstruction on the other breast to produce symmetrical appearance</td>
<td>• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit</td>
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<td></td>
<td>o Treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td>• 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:</td>
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<td></td>
<td>• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit</td>
<td>o Cleft lip and/or palate</td>
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<td>Physician/</td>
<td>• American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</td>
<td>• Severe traumatic skeletal and/or congenital craniofacial deviations</td>
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<td>Physician</td>
<td>• Physician office visits, inpatient and outpatient services</td>
<td>• Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment</td>
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<td>Extender</td>
<td>• Laboratory, X-rays, imaging and pathology services, including</td>
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<td>Professional</td>
<td>Services include but are not limited to:</td>
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<td>Covered Benefit</td>
<td>CHIP and CHIP Perinatal Newborn Members</td>
<td>CHIP Perinatal Members (Unborn Child)</td>
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<td></td>
<td>technical component and/or professional interpretation</td>
<td>• Medically necessary medications, biologicals and materials administered in physician’s office</td>
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<tr>
<td></td>
<td>• Medications, biologicals and materials administered in physician’s office</td>
<td>• Professional component (in/outpatient) of surgical services, including:</td>
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<td>• Allergy testing, serum and injections</td>
<td>o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth</td>
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<td></td>
<td>• Professional component (in/outpatient) of surgical services, including:</td>
<td>o Administration of anesthesia by physician (other than surgeon) or CRNA</td>
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<td>o Surgeons and assistant surgeons for surgical procedures, including appropriate follow-up care</td>
<td>o Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.</td>
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<td></td>
<td>o Administration of anesthesia by physician (other than surgeon) or CRNA</td>
<td>o Surgical services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)</td>
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<td>o Second surgical opinions</td>
<td>o Hospital-based physician services (including physician performed technical and interpretive components)</td>
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<td>o Same-day surgery performed in a hospital without an overnight stay</td>
<td>o 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</td>
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<td></td>
<td>o Invasive diagnostic procedures such as endoscopic examinations</td>
<td>o Professional component of amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for amniocentesis, cordocentesis, and FIUT</td>
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<tr>
<td></td>
<td>• Hospital-based physician services (including physician performed technical and interpretive components)</td>
<td>o Professional component associated with (a) miscarriage or (b) a nonviable 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:</td>
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<td>• Physician and professional services for a mastectomy and breast reconstruction include:</td>
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<td>o All stages of reconstruction on the affected breast</td>
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<td>o External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed</td>
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<td>o Surgery and reconstruction on the other breast to produce symmetrical appearance</td>
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<td>o Treatment of physical complications from the mastectomy and treatment of lymphedemas</td>
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<td>• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Caesarian section</td>
<td>▪ Dilation and curettage (D&amp;C) procedures</td>
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<td></td>
<td>• Physician services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero); physician services associated with miscarriage or nonviable pregnancy include but are not limited to:</td>
<td>▪ Appropriate provider-administered medications</td>
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<td>◦ Dilation and curettage (D&amp;C) procedures</td>
<td>▪ Ultrasounds</td>
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<td>◦ Appropriate provider-administered medications</td>
<td>▪ Histological examination of tissue samples</td>
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<td></td>
<td>◦ Ultrasounds</td>
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<td></td>
<td>◦ Histological examination of tissue samples</td>
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<td></td>
<td>• Physician services medically necessary to support a dentist providing dental services to a CHIP member, such as general anesthesia or intravenous (IV) sedation</td>
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<td></td>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed ad clearly outlined treatment plan to treat:</td>
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<td></td>
<td>◦ Cleft lip and/or palate</td>
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<td>◦ Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment</td>
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Covered Benefit | CHIP and CHIP Perinatal Newborn Members | CHIP Perinatal Members (Unborn Child)
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Prenatal Care and Pre-Pregnancy Family Services and Supplies | • Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services.  
• 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. | • Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:  
  o One visit every 4 weeks for the first 28 weeks of pregnancy  
  o One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy  
  o One visit per week from 36 weeks to delivery  
• More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy  
  o Note: 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:  
  o Interim history (problems, marital status, fetal status)  
  o Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities)  
  o 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
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</table>
| **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 (See Attachment A) | Not a covered benefit, with the exception of a limited set of disposable medical supplies published at [www.txvendordrug.com/formulary/limited-hhs.shtml](http://www.txvendordrug.com/formulary/limited-hhs.shtml), 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 (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 test as indicated by medical condition of client) | Not a covered benefit. |
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<th>CHIP and CHIP Perinatal Newborn Members</th>
<th>CHIP Perinatal Members (Unborn Child)</th>
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<td>period that skilled visits have been approved</td>
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<td>• Speech, physical and occupational therapies</td>
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<td><strong>Notes:</strong></td>
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<td>• Services are not intended to replace the child's caretaker or to provide relief for the caretaker.</td>
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<td>• Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services.</td>
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<tr>
<td>• Services are not intended to replace 24-hour inpatient or skilled nursing facility services.</td>
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<tr>
<td><strong>Inpatient Mental Health Services</strong></td>
<td>• Mental health services, including for serious mental illness, furnished in a freestanding psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including but not limited to neuropsychological and psychological testing.</td>
<td>Not a covered benefit.</td>
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<td>• When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
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<td>• Does not require PCP referral.</td>
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<td><strong>Outpatient Mental Health Services</strong></td>
<td>Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to:</td>
<td>Not a covered benefit.</td>
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<td>• Neuropsychological and psychological testing</td>
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<td>Covered Benefit</td>
<td>CHIP and CHIP Perinatal Newborn Members</td>
<td>CHIP Perinatal Members (Unborn Child)</td>
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<td>Medication management</td>
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Rehabilitative day treatments  
Residential treatment services  
Subacute outpatient services (partial hospitalization or rehabilitative day treatment)  
Skills training (psycho-educational skill development) | |

**Notes:**
- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A qualified mental health provider – community services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412 303(48).
- QMHP-CSs shall be providers working through a DSHS-contracted local mental health authority or a separate DSHS-contracted entity.
- QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include:
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<td>o Individual and group skills training (which can be components of interventions such as day treatment and in-home services)</td>
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<td>o Patient and family education</td>
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<td>o Crisis services</td>
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<td></td>
<td>• Does not require PCP referral.</td>
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<tr>
<td>Inpatient Substance Abuse Treatment Services</td>
<td>• Services include, but are not limited to inpatient and residential substance abuse treatment services, including detoxification, crisis stabilization and 24-hour residential rehabilitation programs</td>
<td>Not a covered benefit.</td>
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<td></td>
<td>• Does not require PCP referral.</td>
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<tr>
<td>Outpatient Substance Abuse Treatment Services</td>
<td>Services include, but are not limited to:</td>
<td>Not a covered benefit.</td>
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<td>• Prevention and intervention services that are provided by physician and nonphysician providers, such as screening, assessment and referral for chemical dependency disorders</td>
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<td></td>
<td>• Intensive outpatient services</td>
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<td></td>
<td>• Partial hospitalization</td>
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<td>Notes:</td>
<td>• Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services and life-skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day.</td>
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<td>• Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services and life-skills training.</td>
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<td></td>
<td>• Does not require PCP referral.</td>
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<td>Rehabilitation Services</td>
<td>Services include, but are not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Habilitation (the process of supplying a child with the means to</td>
<td></td>
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<tr>
<td>Covered Benefit</td>
<td>CHIP and CHIP Perinatal Newborn Members</td>
<td>CHIP Perinatal Members (Unborn Child)</td>
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| Covered Benefit                                     | reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include but are not limited to:  
  o Physical, occupational and speech therapy  
  o Developmental assessment                                                                                                                                                                                                                                                                                                | Not a covered benefit.                                      |
| Hospice Care Services                               | Services include, but are not limited to:  
  • 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  

Notes:  
  • Up to a maximum of 120 days with a six-month life expectancy  
  • Patients electing hospice services may cancel this election at any time.  
  • Services apply to the hospice diagnosis.                                                                                                                                                                                                                                                                                   | MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include but are not limited to:  
  • 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 1 and Level II trauma centers or hospitals meeting equivalent levels  

• 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     |
<table>
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<th>Covered Benefit</th>
<th>CHIP and CHIP Perinatal Newborn Members</th>
<th>CHIP Perinatal Members (Unborn Child)</th>
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</table>
| of care for emergency services | • Emergency ground, air and water transportation  
• Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin | 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 nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)  
• Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinatal member are not a covered benefit. |
| Transplants | Services include, but are not limited to:  
• Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of nonexperimental 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 nonprosthetic 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 | • These services include outreach informing, case management, care coordination and community referral. | Covered benefit. |
Covered Benefit | CHIP and CHIP Perinatal Newborn Members | CHIP Perinatal Members (Unborn Child)
--- | --- | ---
Services | Services include, but are not limited to: | Not a covered benefit unless identified elsewhere in this table.
Drug Benefits | • Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals |  
| | • Drugs and biologicals provided in an inpatient setting |  

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.

Coordination with non-CHIP Covered Services
There are other services not covered through Dell Children’s Health Plan; however, the services are available to CHIP members through other state programs. Dell Children’s Health Plan providers should make every effort to coordinate with these resources in order to maximize the CHIP member’s benefits.

Providers must coordinate with Texas Agency Administered Programs, Case Management Services and Essential Health Services for:

- Dental services
- Texas agency-administered programs and case management services
- Essential public health services
- ECI case management/service coordination
- Mental health targeted case management
- Mental health rehabilitation
- DARS for Blind Children’s Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- DADS hospice services
- WIC (supplemental nutrition for Women, Infants and Children)

All participating providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Dell Children’s Health Plan Member Services at 1-888-596-0268 (TTY 711).

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 at dellchildrenshealthplan.com/providers. If you have problems accessing the information, please call Provider Services at 1-888-821-1108.
Overview
Behavioral health services are covered services for the treatment of mental, emotional or chemical dependency disorders. We provide coverage of medically necessary behavioral health services as indicated below:

1) Texas Health Steps behavioral health services for Medicaid members birth through age 20 that are necessary to correct or ameliorate a mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a mental illness or condition:
   a) Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole (including the Alberto N., et al. v. Traylor, et al. partial settlement agreements) and
   b) May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) of this paragraph

2) For Medicaid members over age 20 and CHIP members, behavioral health-related health care services that:
   a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
   b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
   c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
   d) Are the most appropriate level or supply of service that can safely be provided
   e) Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered
   f) Are not experimental or investigative
   g) Are not primarily for the convenience of the member or provider

For more information about behavioral health services, providers should call 1-888-821-1108, and members should call 1-888-596-0268 (TTY 711).

Behavioral Health Covered Services
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 HMO’s nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including:

- 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
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
  - Assessment
  - Detoxification services
Counseling treatment
- Medication-assisted therapy

- Residential substance use disorder treatment services, including detoxification services
- Substance use disorder treatment, including room and board
- Mental health rehabilitative services
- Mental health targeted case management

CHIP-covered* behavioral health services include:
- Inpatient mental health
- Outpatient mental health
- Inpatient substance abuse
- Outpatient substance abuse

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

**Mental Health Rehabilitative Services and Mental Health Targeted Case Management**

Mental health rehabilitative services and mental health targeted case management must be available to eligible STAR members who require these services based on the appropriate standardized assessment – the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS).

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 and federally-approved protocol as medically necessary to reduce a member’s disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders for children, and to restore the member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member’s rehabilitation plan.

MHR services 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, educational, vocational, behavioral or cognitive interventions to improve the member’s potential for social relationships, occupational or educational achievement and living skills development
- 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 – short-term, intensive and site-based treatment in a group modality to an individual who requires 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)** means services designed to assist members with gaining access to needed medical, social, educational and other services and supports. TCM services include:

- Case management for members who have SED (children 3 through 17 years of age), which includes routine and intensive case management services
- Case management for members who have SPMI (adults 18 years of age or older)

MHR services and TCM services, including any limitations to these services, are described in the most current **TMPPM**, including the *Behavioral Health, Rehabilitation, and Case Management Services Handbook*. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but Dell Children’s Health Plan is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Adult Services (PDF): [www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162](http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162).


Providers of MHR services and TCM services 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 recommend a level of care. Providers must use these tools to recommend a level of care to Dell Children’s Health Plan by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. A provider entity must attest to Dell Children’s Health Plan that the organization has the ability to provide, either directly or through subcontract, the full array of RRUMG services to members.

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM Services. These criteria are located in Chapter 15.1 of the *HHSC Uniform Managed Care Manual*.

**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 outpatient mental health services. Reimbursement for these services
will be determined according to the provider agreement. Covered benefits are as outlined in the *TMPPM*.

**Primary and Specialty Services**

Members have access to the following primary and specialty 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 of members
  - Furnished by the ordering provider at a lab located at or near the provider’s office
  - In most cases, our network of reference labs is conveniently located at or near the provider’s office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments

**Behavioral Health Care Provider Responsibilities**

We maintain a behavioral health provider network that includes psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area. Our members can self-refer to a participating behavioral health provider by calling Member Services at 1-888-596-0268 (TTY 711).

Primary care providers providing behavioral health services 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 [delchildrenshealthplan.com/providers](http://delchildrenshealthplan.com/providers).

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. 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 seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Primary care providers 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 his or her scope of practice.

Primary care providers can offer behavioral health services when:

- Clinically appropriate and within the scope of his or her 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 primary care provider.

The services rendered are within the scope of the benefit plan.

Behavioral health providers:

- Must refer members with known or suspected physical health problems or disorders to the primary care provider for examination and treatment.
- Must utilize the most current DSM multi-axial classification when assessing members; the Health and Human Services Commission (HHSC) may require the use of other assessment instruments/outcome measures in addition to the DSM; network providers must document DSM and assessment/outcome information in the member’s medical record.
- May only provide physical health care services if licensed to do so.
- Must send initial and quarterly summary reports of a member’s behavioral health status to the primary care provider with the member’s consent.

Care Continuity and Coordination Guidelines

Primary care providers and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies.

Our care continuity and coordination guidelines for primary care providers 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 one 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 primary care provider when the member has seen a behavioral health provider (the form can be found on our website at dellchildrenshealthplan.com/providers)
- 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 primary care provider
- Contacting the primary care provider when a behavioral health provider changes the behavioral health treatment plan
- Contacting the behavioral health provider when the primary care provider determines the member’s medical condition could reasonably be expected to affect the member’s mental health treatment planning or outcome and documenting the information on the coordination of care/treatment summary
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. And 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 911 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 occurs when the member is:
- Suicidal
- Homicidal
- Violent towards 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 precertification 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.

Precertification and Referrals for Behavioral Health
Members may self-refer to any Dell Children’s Health Plan network behavioral health services provider by calling Member Services at 1-888-596-0268 (TTY 711). No precertification or referral is required from the PCP.

Providers may request precertification or refer members for services by:
- Calling Provider Services at 1-888-821-1108.
- Faxing information to our behavioral health fax lines at 1-877-434-7578 for inpatient services and 1-800-505-1193 for outpatient services. The mental health rehabilitative and targeted case management services fax is 1-866-877-5229.

Our staff is available 24 hours a day, 7 days a week and 365 days a year for routine, crisis or emergency calls and authorization requests. We are responsible for authorized inpatient hospital services, including freestanding psychiatric facilities.
**Court-Ordered Commitment**

We cover inpatient and outpatient psychiatric services to STAR and CHIP members who have been ordered by a court of competent jurisdiction under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, to receive the services under a court-ordered commitment to an inpatient mental health facility.

Dell Children’s Health Plan:

- Will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination
- Will comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code
- Will not allow members ordered to receive treatment under the provisions of the Texas Health and Safety Code to appeal the commitment through our complaint or appeals processes

A court-order commitment to an inpatient mental health facility as a condition of probation is a noncapitated service payable under Medicaid FFS.
CHAPTER 8: QUALITY MANAGEMENT

Overview
We maintain a comprehensive quality management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The quality management program goals and outcomes are available, upon request, to providers and members. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program. If you would like more information about our quality management program goals, processes and outcomes, call Provider Services at 1-888-821-1108.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan’s specific population occurs on an annual basis. This includes not only age/sex distribution but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define high-volume or problem-prone areas. HEDIS¹ performance is evaluated annually and compared against national benchmarks. CAHPS² evaluates member satisfaction and experience annually. Performance is analyzed for barriers and best practices, and interventions are developed to improve performance.

We maintain a quality committee structure that includes a medical advisory committee (MAC) and a credentialing committee (with participation from network physicians and practitioners), which also serves as a peer review committee. These committees are overseen by the quality management committee structure.

Note: All providers must allow Dell Children’s Health Plan to use performance data in cooperation with our quality improvement program and activities.

1 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
2 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Quality Management Committee
The purpose of the quality management committee (QMC) is to maintain quality as a cornerstone of our culture. The committee serves as an instrument of change through demonstrable improvement in care and service. The QMC’s responsibilities are to:

- Establish strategic direction — monitor and support implementation of the quality management program
- Establish processes and structure that ensures accreditation compliance
- Recommend policy decisions through the review and approval of Texas policies and by the acceptance of corporate QM policies and procedures, as appropriate
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the health plan
- Review HEDIS and member satisfaction survey data and action plans for improvement
- Review, monitor and evaluate program compliance against Dell Children’s Health Plan, state, federal and accreditation standards
• Analyze and evaluate the results of QI activities through review, and approve the annual quality management program description, work plan and evaluation
• Determine and describe the program's overall effectiveness
• Consider the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QM program and determine whether to restructure or change the QM program for the subsequent year based on its findings
• Provide oversight and ensure compliance of delegated services
• Assure inter-departmental collaboration, coordination and communication of quality improvement activities
• Measure compliance to medical and behavioral health practice guidelines
• Monitor continuity of care between medical and behavioral health services
• Monitor accessibility and availability with cultural assessment
• Publicly make information available to members and practitioners about network hospitals’ actions to improve patient safety
• Make information available about the QM program to members and practitioners
• Assure the availability of QM program minutes to the appropriate state regulatory agency, as applicable
• Ensure practitioner participation in the QI program through planning, design, implementation or review, as well as through direct input from the practitioner members of the QM committee and MAC, or other mechanisms that allow practitioner involvement
• Identify needed actions
• Follow up as appropriate

Medical Advisory Committee
The medical advisory committee (MAC) assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. It oversees the credentialing and peer review committee, which provides a systematic approach for monitoring the quality and appropriateness of care. The MAC advises the health plan administration in any aspect of its policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer-review process, the quality management program and the health care management services program.

The MAC’s responsibilities are to:
• Utilize ongoing peer review system to assess levels of care and quality of care provided
• Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities
• Review and provide input, based upon the characteristics of the local delivery system; approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization (clinical practice guidelines as well as utilization management criteria)
• Review clinical study design and results
• Develop and approve action plans/recommendations regarding clinical quality improvement studies
• Consider/act in regard to physician sanctions
• Approve recommendations from the credentialing committee to credential/recredential providers for participation in the plan
- Review, and provide input, to: credentialing/recredentialing policies and procedures, clinically oriented QM policies and procedures, utilization management policies and procedures and disease/case management policies and procedures
- Review and provide feedback regarding new technologies
- Oversee compliance of delegated services

**Credentialing Committee**
The credentialing committee’s purpose is to credential and recredential all participating physicians according to plan, state and federal accreditation standards. Committee responsibilities include:

- Conduct reviews for all providers who apply for participation in the network
- Review all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports
- Approve or deny providers submitted by a delegated credentialing entity
- Review and update credentialing policies and procedures
- Report physician corrective actions and sanctions imposed based upon recredentialing activity to the MAC
- Approve or deny providers for participation in the network and report decisions to the MAC
- Oversee delegated credentialing relationships

**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 MAC 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 quality management committee. The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

**Clinical Practice Guidelines**
Using nationally recognized, scientific, evidence-based standards of care, we work with providers to develop clinical policies and guidelines for the care of members. The super MAC oversees and directs us in formulating, adopting and monitoring guidelines.
Clinical practice guidelines are located on our secure website at dellchildrenshealthplan.com/providers. A copy of the guidelines can be printed from the website, or you may call Provider Services at 1-888-821-1108 to receive a printed copy.

We select at least four evidence-based clinical practice guidelines that are relevant to the member population. We measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

Focus Studies and Utilization Management Reporting Requirements
Quality management is involved in conducting clinical and service utilization studies that may or may not require medical record review. We conduct gap analysis of the data and share opportunities for improvement with our network 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 for determining 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 Dell Children’s Health Plan.
Overview
We operate a comprehensive medical management program known as precertification and utilization management. For questions about the utilization management (UM) processes, including UM criteria, call Provider Services at 1-888-821-1108.

Medical Review Criteria
Dell Children’s Health Plan utilizes the Anthem, parent company of Amerigroup, nationally recognized, evidence-based medical policies and clinical utilization management guidelines. These policies are publicly available on the Dell Children’s Health Plan medical policy and clinical UM guideline subsidiary website at dellchildrenshealthplan.com/providers. These policies and guidelines can be obtained in hard copy by contacting Provider Services at 1-888-821-1108.

McKesson InterQual level of care criteria is used only for medical necessity review for medical inpatient concurrent review, inpatient site of service appropriateness, home health and outpatient rehabilitation. Anthem behavioral health medical policies and clinical utilization management guidelines will be used for all behavioral health reviews.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both Anthem medical policy and McKesson InterQual level of care criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

We use nationally recognized standards of care for clinical decision support for medical management coverage decisions. The criteria provides a system for screening proposed medical care based on member-specific best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. We work with providers and other industry experts to develop and/or approve clinical practice guidelines. The medical advisory committee (MAC) assists us in formalizing and monitoring guidelines. Criteria include:

- Acute care
- Rehabilitation
- Subacute care
- Home care
- Surgery and procedures
- Imaging studies and X-rays
- Texas Medicaid Provider Procedures Manual (TMPPM)

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 and 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 precertification 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.

**Precertification** 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.

**Utilization Management Decision Making Affirmative Statements**
Dell Children’s Health Plan, as a corporation and as individuals involved in utilization management (UM) decisions, is governed by the following statements:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- Dell Children’s Health Plan does not specifically 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.

**Medically Necessary Services**
Medically necessary means:

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

3) For Medicaid members over age 20 and CHIP members, behavioral health services that:
   a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
   b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
   c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
   d) Are the most appropriate level or supply of service that can safely be provided
   e) Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered
   f) Are not experimental or investigative
   g) Are not primarily for the convenience of the member or provider

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.

**Precertification/Notification Process**

For services that require precertification, 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. To determine if precertification or notification is required, see our Precertification Lookup Tool at dellchildrenshealthplan.com/providers.

Requests for precertification may be submitted for review and approval as indicated below:

Inpatient/outpatient surgeries and other general requests fax: 1-800-964-3627
Behavioral Health fax—inpatient: 1-877-434-7578
Behavioral Health fax—outpatient: 1-866-877-5229
Mental health rehabilitative and targeted case management services fax: 1-866-877-5229
Providers should submit a prior authorization request form, which is available on the provider website at dellchildrenshealthplan.com/providers or by calling Provider Services at 1-888-821-1108. Include the following information:

- Member’s name and ID
- Name, telephone number and fax number of physician performing the service
- Name of the facility and telephone number where the service is to be performed
- Date(s) of service
- Diagnosis
- Name of procedure to be performed with CPT/HCPCS and applicable modifiers
- Place of service the procedure or service will be performed (office, home, outpatient, inpatient, etc.)
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

We are staffed with clinical professionals who coordinate services provided to members. These professionals are available 24 hours a day, 7 days a week to accept precertification requests. Upon receipt of a request for precertification, a Dell Children’s Health Plan precertification assistant will verify 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. When appropriate, the reviewer will assist the requesting physician in identifying alternatives for health care delivery as supported by a Dell Children’s Health Plan medical director.

When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting physician. If the provider identifies the request as urgent (expedited service authorizations), the decision will be made within one business day but not later than 72 hours or three calendar days of receipt of the request.

If the precertification documentation is incomplete or inadequate, the reviewer will not approve coverage of the request. In such instances, the reviewer will notify the provider to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the Dell Children’s Health Plan 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.

The appropriate notice of proposed action will be mailed to the member, the servicing provider, the requesting/ordering provider, and the member’s primary care physician. The notice includes an explanation of the member’s appeal rights and fair hearing/IRO rights and process.

**Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements**

We require precertification for coverage of selected nonemergent outpatient and ancillary services. To determine if precertification or notification is required, see our Precertification Lookup Tool at dellchildrenshealthplan.com/providers.

**Nonemergent Inpatient Admissions**

We require precertification of all inpatient nonemergent admissions, except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s). For a mother and her newborn(s), the guidelines are a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by Cesarean section. We require precertification of maternity inpatient stays for any portion in excess of these time frames. The referring primary care provider or specialist physician is responsible for precertification. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request, or at least 72 hours prior to the scheduled admission.

The hospital can confirm that an authorization is on file by calling our automated Provider Inquiry Line at 1-888-821-1108 or by accessing https://www.availity.com. If coverage of an admission has not been approved, the facility should contact us at 1-888-821-1108 so we can contact the physician directly to resolve the issue.

**Emergent Admission Notification Requirements**

We request immediate notification by network hospitals of emergent admissions. Our medical management staff will verify eligibility and determine benefit coverage.

**Inpatient Admission Reviews**

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day of notification of admission.

Our utilization review clinician determines the member’s medical status through onsite review and/or communication with the hospital’s utilization review department. Appropriateness of stay is documented, and concurrent review is initiated. Cases that do not meet medical necessity or have quality care concerns may be referred to the medical director for review. If a case does not meet medical necessity, the attending provider will be afforded the opportunity to discuss the case with the Dell Children’s Health Plan medical director prior to the determination. When appropriate, members may be referred to a Dell Children’s Health Plan disease management program.

**Inpatient Concurrent Review**

Each network hospital will have an assigned utilization management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record at the hospital by fax or by telephone to determine the authorization of coverage for a continued stay.
The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient’s condition is such that it is unlikely to change within the upcoming 24 hours, at which time the reviews can be done less frequently than daily.

We will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for C-section or vaginal deliveries as predetermined by state law. Other exceptions are made by the medical director on a case-by-case basis.

When the clinical information received meets medical necessity criteria, approved days and bed level (if appropriate) coverage will be communicated to the hospital for the continued stay. If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will afford the attending physician the opportunity to discuss the case prior to making a determination. If the medical director’s decision is to deny the request, the appropriate notice of action will be mailed to the hospital, treating or attending practitioner, member’s primary care provider and member. The notice of action includes an explanation of the member’s appeal rights and fair hearing /IRO rights and process.

When a Dell Children’s Health Plan UM clinician reviews the medical record at the hospital, he or she also may attempt to meet with the member and/or family to discuss any discharge-planning needs. The UM clinician will also attempt to verify that the member or family is aware of the member’s primary care provider’s name, address and telephone number. The UM clinician will conduct continued stay reviews daily and review discharge plans, unless the patient’s condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined. At that time, reviews can be done less frequently than daily.

We will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization will be made for confinements when the length of stay is predetermined by state law. Examples of confinement and/or treatment include C-section or vaginal deliveries. Exceptions are made by the medical director.

Poststabilization Care Services
Poststabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient’s condition. We will adjudicate emergency and poststabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

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. If the discharge is approved, 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 primary care provider regarding follow-up care after discharge. The primary care provider is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending physician is also responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider. The follow-up visit must occur within seven calendar days of discharge.
When additional/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:

- Hospice facility
- Convalescent facility
- Home health care program (e.g., 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.

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, DME, pharmacy and follow-up visits to practitioners or outpatient procedures.

**Confidentiality of Information**
Utilization management, case management, 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 used for the purposes defined above. 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 utilization management and related processes.

**Urgent/After-Hours Care**
We require members to contact their primary care provider in situations where urgent, unscheduled care is necessary. If the PCP is unable to see the member, you can refer him or her to one of our participating urgent care centers. If the member needs care during nonbusiness hours, he or she can be seen by a provider who participates in our after-hours care program. Precertification by Dell Children’s Health Plan is not required for a member to access a participating urgent care center or a provider participating with after-hours care.

**Utilization Timeliness Standards**
Utilization review timeliness standards:

- **Nonurgent preservice:** For precertification of nonurgent care, a decision will be made within three business days.
- **Urgent preservice:** For precertification of urgent preservice care, a decision will be made within one business day but not later than 72 hours or three calendar days of receipt of the request for service.
- **Urgent concurrent:** For urgent concurrent care, a decision will be made within 24 hours of the receipt of request for service or notification of inpatient admission.
- **Postservice:** For postservice care, a decision will be made within 30 calendar days.
- **Extensions:** Based upon insufficient information to make a decision, extensions to the standard time frames may be appropriate and can be used with certain restrictions. Appropriate notifications will be made if an extension is applicable.

**Self-referrals**
We may require members to seek a referral from their primary care provider prior to accessing nonemergency specialty physical health services, with the exception of:
<table>
<thead>
<tr>
<th>Service</th>
<th>Authorization for continued services</th>
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| 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                                                                                                                                 |
| Behavioral Health - (nonparticipating providers must seek prior approval from Dell Children’s Health Plan) | Members may self-refer to any Dell Children’s Health Plan network behavioral health services provider by calling Member Services at 1-888-596-0268 (TTY 711). No prior approval from the primary care provider is required.  
Providers may refer members for services by:  
• Calling Provider Services at 1-888-821-1108  
• Faxing referral information to our dedicated behavioral health faxes at 1-877-434-7578 for inpatient and 1-800-505-1193 for outpatient  
Our staff is available 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests. |
| Texas Health Steps                           | Members may self-refer to any Texas Health Steps-certified provider.                                                                                                                                                           |
| Early Childhood Intervention (ECI)           | Members may self-refer to local contracted ECI service providers. Dell Children’s Health Plan providers must provide referral information to the legally authorized representative 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 seven calendar days from the day the provider identifies the member. |
| Emergent care                                | No precertification or notification is required, regardless of network status with Dell Children’s Health Plan.                                                                                                               |
| Family planning/ Sexually Transmitted Disease (STD) | Providers submitting family planning claims should submit them first to Dell Children’s Health Plan to receive an EOB. Payment will be received from TMHP. Once you receive the Dell Children’s Health Plan EOB, submit family planning claims to TMHP at the following address, along with the Dell Children’s Health Plan EOB denial:  
Texas Medicaid & Healthcare Partnership  
Attn: Claims  
P.O. Box 200555  
Austin, TX 78720-0555  
Electronic claims may be submitted through TXMedConnect. Information for submitting electronic claims can be found at www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx. |
<p>| Sterilization                                | Providers submitting sterilization claims should submit them first to Dell Children’s Health Plan to receive an EOB. Payment will be received from TMHP. Once you receive the |</p>
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<tr>
<th>Service</th>
<th>Authorization for continued services</th>
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<tr>
<td>Dell Children’s Health Plan EOB, submit family sterilization claims to TMHP at the following address, along with the Dell Children’s Health Plan EOB denial:</td>
<td></td>
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<tr>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
<td></td>
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<tr>
<td>Attn: Claims</td>
<td></td>
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<tr>
<td>P.O. Box 200555</td>
<td></td>
</tr>
<tr>
<td>Austin, TX 78720-0555</td>
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<tr>
<td>Electronic claims may be submitted through TXMedConnect. Information for submitting electronic claims can be found at <a href="http://www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx">www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx</a>.</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis, Sexually Transmitted Diseases, HIV/AIDS Testing and Counseling Services</td>
<td>No precertification or notification is required for these services, regardless of network status with Dell Children’s Health Plan.</td>
</tr>
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**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 Dell Children’s Health Plan 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. This requirement is described in the following paragraphs.

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, which we may request to conduct business and make decisions about care, such as a member’s medical record, to make an authorization determination or 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 restricted access 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 Dell Children’s Health Plan 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 Dell Children’s Health Plan.
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 Dell Children’s Health Plan 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 are required to review all member information received from Dell Children’s Health Plan to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, call Provider Services at 1-888-821-1108 for help.
CHAPTER 10: MEMBER MANAGEMENT SUPPORT

Appointment Scheduling
We, through our participating providers, ensure members have access to primary care services for routine, urgent and emergency services, as well as specialty care services for chronic and complex care. Providers will respond to Dell Children’s Health Plan member’s needs and requests in a timely manner. The primary care provider should make every effort to schedule our members for appointments using the guidelines outlined in the Provider Rights and Responsibilities chapter of this manual.

Case Management
Our case management program is part of a comprehensive health care management services program offering a continuum of services that include case management, disease management, care coordination and utilization management. The program helps to reduce barriers by identifying the unmet needs of members and assisting them in meeting those needs. This may involve coordinating care, assisting members to access community resources, providing disease-specific education or any number of interventions designed to improve the quality of life and functionality of members. The programs are designed to make more efficient use of limited health care resources.

Scope of the case management program:
- Member identification and screening
- Initial and ongoing assessment
- Problem-based, comprehensive care planning that includes measurable goals and interventions tailored to the acuity level of the member, as determined by the initial assessment
- Coordination of care with primary care providers and specialty providers
- Member education
- Effective member and provider communication
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Objectives of the case management program:
- Maintain a cost-effective case management system to manage the needs of members with high case management 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 case management 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 Dell Children’s Health Plan staff.
• Improve member and provider satisfaction and retention.
• Comply with applicable contractual and regulatory requirements related to case management.
• Identify opportunities to transition members to more appropriate federal/state programs.
• 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 case management 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 case management services 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 Case Management
Any Dell Children’s Health Plan member is eligible for case management. Members are identified through continuous case-finding methods that include but are not limited to precertification, admission review and/or provider or member requests.

Hours of Operation
Our case managers are licensed nurses and social workers, available Monday through Friday from 8 a.m. to 5 p.m. Central time. Confidential voicemail is available 24 hours a day.

Contact Information
To contact a case manager, call Provider Services at 1-888-821-1108 or your local health plan.

Members with Special Health Care Needs (MSHCN)
MSHCN means a member who both:
• 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, and
• Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel

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 care management. This includes the development of a care 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 have direct access to a specialist as appropriate for the member’s condition and identified needs, such as a standing referral to a specialist (see the Specialty Referrals section for more information). MSHCN members may also have a specialist designated to serve as a primary care provider (see the Specialist as a Primary Care Provider section for more information).
To refer a patient who may qualify as having special health care needs, contact Provider Services at 1-888-821-1108 or your local health plan.

**Comprehensive Member Assessment**

A case manager will conduct a comprehensive assessment to further determine a member’s needs. The assessment will include a range of questions identifying and evaluating the member’s:

- Medical condition
- Functional status
- Goals
- Life environment
- Support systems
- Emotional status
- Capability for self-care
- Current treatment plan

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

**Communicable Disease Services**

We cover communicable disease services to members. Communicable disease 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 of our provider network through the Texas Department of Health and Environmental Control clinics without any restrictions. Providers should encourage members to receive TB, STD and HIV/AIDS services through Dell Children’s Health Plan to ensure continuity and coordination of a member’s total care.

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

**Control and Prevention of Communicable Diseases**

We will coordinate with public health entities in each service area regarding the provision of essential public health care services. We must meet the following requirements:

- 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.
- 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.
**Health Promotion**

We strive to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are disseminated to our members and health education classes are coordinated with Dell Children’s Health Plan-contracted community organizations and network providers.

We offer our members education and information regarding their health. Ongoing projects include:

- Annual member newsletter for STAR and CHIP members
- Creation and distribution of *Dell Children’s Health Plan Tips*, our health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Relationship development with community-based organizations to enhance opportunities for members

**Women Infants and Children Program**

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

- Pregnant women
- Women who are breastfeeding a baby under one year of age
- Women who have had a baby in the past six months
- Parents, step parents and foster parents of infants and children age four and younger

The above members 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.

**Taking Care of Baby and Me® Program**

We offer the Taking Care of Baby and Me program to all expectant mothers, except CHIP Perinatal members. The program objective is to provide coordinated, comprehensive prenatal management with the intent of identifying members prior to an adverse health event. We provide members with care management, education and incentive gift rewards to promote healthy outcomes.

Taking Care of Baby and Me includes an obstetric (OB) case management program to improve birth outcomes of high-risk pregnant members. A team of experienced OB registered nurses supplements the care and information you provide to your patients. Members with the following conditions and issues will benefit most from case management:

- Multiple gestation
- History of preterm delivery with a past pregnancy
- Current preterm labor
- Noncompliant in keeping appointments
- Noncompliant in following their prescribed plan of care
Please help us identify Dell Children’s Health Plan members who may benefit from OB case management. You can make referrals to the case management program by calling 1-888-821-1108 and asking for an OB case manager.

Our members receive information about Taking Care of Baby and Me (including a pregnancy book) upon enrolling in the program. After completing certain checkups, members are eligible for merchandise gift cards through the Healthy Rewards program, which is part of our value-added services.

Notification at 1-888-821-1108 is required at the first prenatal visit. Taking Care of Baby and Me provides care management to:

- Improve the level of knowledge of the member about her pregnancy stage.
- Create systems that support the delivery of quality care.
- Measure and maintain, or improve member outcomes related to the care delivered.
- Facilitate care with providers to promote collaboration, coordination and continuity of care.

Health education is provided and encouraged through prenatal and postpartum health promotion packets. These packets include information on foster program participation and gift incentives. Information about available health-related community services is provided to members as appropriate. All identified pregnant members will automatically receive information on Taking Care of Baby and Me.
CHAPTER 11: STAR AND CHIP SPECIAL ACCESS REQUIREMENTS

General Transportation and Ambulance/Wheelchair Van
The Medical Transportation Program (MTP) provides Medicaid members and their attendants nonemergency transportation services (by the most cost-effective modes) to a reasonably close and medically appropriate provider. MTP can be reached at 1-877-633-8747.

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.

Interpreter/Translation Services
Dell Children’s Health Plan provides language interpretation services to translate multiple languages at no cost to providers or members. We do this through the Language Line, which may be accessed by calling Provider Services at 1-888-821-1108. Provider Services will then contact the Language Line as a third-party conversation.

Persons who are deaf or hearing impaired should call 711 (TTY) and ask them to call Member Services.

Dell Children’s Health Plan 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. We 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 at 1-888-821-1108 or your local health plan. Interpreter services should be requested at least 72 hours before the appointment.

MCO/Provider Coordination
Dell Children’s Health Plan clinical and operational staff is 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)
- Women, Infants and Children (WIC)
- Case Management for children and pregnant women
- Children with special health care needs (CSHCN)
- Medically dependent children (MDCP)
- Medical transportation
- School health and related services (SHARS)
Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development

Contact us at 1-888-821-1108 for assistance with utilization management and case/disease management for your Dell Children’s Health Plan 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.

Provider should be culturally sensitive to members and or parents/guardians. Some action or words a provider uses may be interpreted by the member and or parent/guardian in the wrong way. If you need additional information about cultural sensitivity, contact Provider Services at 1-888-821-1108.

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 specialty physician.
Overview
Our Disease Management Centralized Care Unit (DMCCU) is 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. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance abuse disorder

In addition to our 11 condition-specific disease management programs, our member-centric, holistic approach also allows us to manage members with obesity.

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
- Continuous self-management education
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Disease management clinical practice guidelines are located at dellchildrenshealthplan.com/providers. A copy of the guidelines can be printed from the website, or call Provider Services at 1-888-821-1108 to receive a copy.

Who Is Eligible?
All members with the listed conditions above are eligible. We identify them through:

- Continuous case-finding welcome calls
- Claims mining
- Referrals

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers 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. They are provided with continuous education on self-management concepts including primary prevention, behavior modification and compliance/surveillance as well as case/care management for high-risk members. 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 DMCCU case managers are licensed nurses and social workers. They are available 8:30 a.m. to 5:30 p.m. local time.

Confidential voicemail is available 24 hours a day. The Nurse Helpline is available for our members 24 hours a day, 7 days a week.

**Contact Information**
You can call a DMCCU team member at 1-888-830-4300. DMCCU program content is located at dellchildrenshealthplan.com/providers. Printed copies are available upon request. Members can obtain information about the DMCCU program by calling 1-888-830-4300.

**Disease Management Centralized Care Unit Provider Rights and Responsibilities**
You have the right to:
- Have information about Dell Children’s Health Plan, 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 DMCCU as outlined in the Dell Children’s Health Plan provider complaint and grievance procedure
CHAPTER 13: PROVIDER RESPONSIBILITIES

Provider Rights and Responsibilities

Providers’ Bill of Rights
Each health care provider who contracts with HHSC or subcontracts with Dell Children’s Health Plan 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 nontreatment
  - 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 and fair hearing procedures
- To have access to Dell Children’s Health Plan policies and procedures covering the authorization of services
- To be notified of any decision by Dell Children’s Health Plan 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 that Dell Children’s Health Plan 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 his or her license or certification under applicable state law solely on the basis of that license or certification

Network Provider General Responsibilities

- Provide Dell Children’s Health Plan members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Dell Children’s Health Plan clinical and nonclinical guidelines and within the practice of your professional license.
- Treat all Dell Children’s Health Plan members in a fair and nondiscriminatory manner and with respect and consideration.
- Abide by the terms of your Dell Children’s Health Plan Participating Provider Agreement.
- Comply with all of Dell Children’s Health Plan policies and procedures, including those found in this provider manual and any future updates or supplements.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within the Dell Children’s Health Plan network.
- Verify member eligibility and obtain precertification for services as required by Dell Children’s Health Plan.
- Ensure members understand the right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Dell Children’s Health Plan medical records guidelines, as outlined in the Member Record Standards section and applicable HIPAA regulations.
- Maintain a facility that promotes patient safety.
- Participate in the Dell Children’s Health Plan Quality Improvement Program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify Dell Children’s Health Plan 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 Dell Children’s Health Plan if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in an amount that meets Dell Children’s Health Plan credentialing requirements and/or state-mandated requirements.
- Notify Dell Children’s Health Plan promptly if there is a change in your physical office or remittance address, tax identification number or any other type of demographic change.

**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 primary care provider at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. Dell Children’s Health Plan will 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 Dell Children’s Health Plan may serve as witness to an advance directive or as a member’s designated agent or representative. Dell Children’s Health Plan notes the presence of advance directives in the medical records when conducting medical chart audits.

**Americans with Disabilities Act Requirements**

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 us 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:

- 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 within 10 days of 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 time lines stated in the provider’s agreement. Please submit changes to:

Attn: Provider Relations
Dell Children’s Health Plan
4515 Seton Center Parkway, Suite 310
Austin, TX 78759
shpproviderservices@seton.org

Appointments

Routine Care
Health care for covered preventive and medically necessary health care services that are nonemergent or nonurgent 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 primary care provider or primary care provider 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 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.
<table>
<thead>
<tr>
<th>Standard Name</th>
<th>Dell Children’s Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Immediately upon member presentation at the service delivery site</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine primary care</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Routine specialty care</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>Preventive health: adult (STAR)</td>
<td>Within 90 days</td>
</tr>
<tr>
<td>Preventive health: child (new member, STAR)</td>
<td>For new members birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps, should be offered as soon as practicable and within 90 days of enrollment.</td>
</tr>
<tr>
<td>Preventive health: child (CHIP only)</td>
<td>Within 60 days</td>
</tr>
<tr>
<td>Preventive health: newborn</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Texas Health Steps medical checkups (STAR) age birth through 35 months of age</td>
<td>For an existing member from birth through 35 months of age, due based on dates in the TMPPM. Considered timely if within 60 days of the due date based on the member’s date of birth.</td>
</tr>
<tr>
<td>Texas Health Steps annual medical checkup (STAR) age 3 years and older</td>
<td>For an existing member age 3 years or older, due on the child’s birthday. Considered timely if no later than 364 calendar days after the child’s birthday.</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Pregnancy high-risk/third trimester</td>
<td>Within 5 days or immediately if an emergency exists</td>
</tr>
<tr>
<td>Behavioral health: non-life-threatening emergency</td>
<td>Within 6 hours (NCQA)</td>
</tr>
<tr>
<td>Behavioral health: urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Behavioral health: routine care</td>
<td>The earlier of 10 business days or 14 calendar days</td>
</tr>
<tr>
<td>After-hours care</td>
<td>For primary care providers: Practitioners accessible 24/7 directly or through answering service. Answering service or recording assistance is in English and Spanish. Member reaches on-call physician or medical staff within 30 minutes.</td>
</tr>
</tbody>
</table>

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**

Dell Children’s Health Plan 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.

Dell Children’s Health Plan 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 1-888-821-1108 or the local health plan member advocate to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining
preventive health visits and adhering to the primary care provider’s recommended plan of care. Providers may not bill us or our members for missed appointments.

**Continuity of Care**
The care of newly enrolled members may not be disrupted or interrupted. This is true for care that falls within the scope of benefits. We will work to provide continuity in the care of newly enrolled members whose health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. Pregnant Dell Children’s Health Plan members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their 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.

We pay a 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 us, whichever is shorter.

**Member Moves Out of Service Area**
We provide or pay 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 he or she is enrolled in Dell Children’s Health Plan.

**Pre-Existing Condition Not Imposed**
We do not impose any pre-existing condition limitations or exclusions. We do not require evidence of insurability to provide coverage to any member.

**Covering Physicians**
During a provider’s absence or unavailability, he or she needs to arrange for coverage for his or her members. The provider will either:
- Make arrangements with one or more network providers to provide care for his or her 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.

**Credentialing and Recredentialing**
To be reimbursed for services rendered to Medicaid Managed Care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they have enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

Providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.
As an applicant for participation in our network, each provider has the right to review information obtained from other sources during the credentialing process. Upon notification from us of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

We will complete the initial credentialing process and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after receipt of a complete application. If an application does not include required information, we will send the applicant written notice of all missing information no later than five business days after receipt of the application.

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D, and E, regarding providers joining established medical groups or professional practices that are already contracted with us, our claims system will be able to process claims from the provider as if the provider was fully contracted, no later than 30 days after receipt of a complete application, even if we have not yet completed the credentialing process.

At least once every three years, we will review and approve the credentials of all participating licensed and unlicensed providers who participate in the Dell Children’s Health Plan network. The process will take into consideration provider performance data including member complaints and appeals, quality of care and utilization management.

Providers are required to notify us of a change in address or practice status within 10 days of 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 time lines stated in the provider’s agreement. Submit changes to:

Provider Relations
Dell Children’s Health Plan
4515 Seton Center Parkway, Suite 310
Austin, TX 78758

Credentialing Decision Appeal Process
If an adverse initial credentialing or recredentialing decision is made, Dell Children’s Health Plan will notify the provider of unsuccessful credentialing within 10 business days. The notification shall include the reason for the adverse decision, a request for additional information (if applicable), and the right of the provider to request a hearing within thirty (30) business days.

Practitioner Office Site Quality
We establish standards and thresholds for office site criteria and medical/treatment record-keeping practices. This applies to all practitioners within the scope of credentialing.

To protect the health and safety of our members, we developed a process for evaluating a physician office site for one or more of the following reasons:

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space or adequacy of medical/treatment records
• Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members’ health and well-being
• When a pattern related to the quality of the site is identified
• At the time of initial credentialing and/or recredentialing as outlined by contractual requirement
• To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations. The site review includes but is not limited to an assessment of the following:
• Physical accessibility
• Physical appearance
• Adequacy of waiting and examining room space
• Appointment availability
• Adequacy of medical record keeping to include current, detailed and organized documentation and confidentiality practices (medical record score marked separately)
• Medical records shall be available for review upon reasonable advanced notice (five business days)
• Medical records stored in a secure manner away from public access
• Adequate policies covering the duties of physician assistants, advanced practice nurses, dental hygienists and/or other individuals hired to assess the health needs of members (duties, licensure, delegation, collaboration and supervision)

If a physician uses radiology equipment at their practice location, current required certificates must be obtained and evidenced in the credentialing files.

If a physician provides laboratory services at their practice location, current Clinical Laboratory Improvement Act (CLIA) and/or similar certificates must be obtained and evidenced in the credentialing files.

The results of the site review and medical record review are discussed with a staff member at the completion of the review. The complete office review tool will be signed by the provider or the provider’s office representative as evidence of discussion of the findings. The office review tool will be included in the provider’s credentialing file. The minimum passing score for the site review and the medical record review is 90 percent. If the site review or medical record review falls below this score, the credentialing committee may decide to either (1) require the provider to reapply for credentialing after at least six months have passed or (2) enter into a corrective action plan, including a follow-up site visit. A follow-up is required every six months until the site complies with the standards. The corrective action plan will be presented for approval to the credentialing committee.

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 primary care provider. 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 seven calendar days from the day the provider identifies the member. The Department of Assistive and Rehabilitative Services – Division for Early Childhood Intervention Services provides information and publications on its website at www.dars.state.tx.us/ecis/index.shtml, 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. Dell Children’s Health Plan 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 primary care provider or Dell Children’s Health Plan 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 Dell Children’s Health Plan and the primary care provider 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 included in the plan. Program-provided services are services that are provided by the ECI contractor. 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 Dell Children’s Health Plan.

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.

Dell Children’s Health Plan 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. Dell Children’s Health Plan is not responsible for payment of these services; ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP).

Eligibility Verification
Primary care providers can obtain listings of members assigned to their panels online at https://www.availity.com. If a member calls Dell Children’s Health Plan to change his or her primary care provider, the change will be effective the same business day. The primary care provider should verify that each Dell Children’s Health Plan member receiving treatment in his or her office is on the membership listing. For questions regarding a member’s eligibility, providers may visit https://www.availity.com or call the automated Provider Inquiry Line at 1-888-821-1108.

Emergency Services
We provide a Nurse HelpLine service with clinical staff to provide triage advice, referral (if necessary) and make arrangements for treatment of 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 911 emergency system, and we do not deny access to emergency services. Emergency services are provided to members without requiring precertification. 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 the member would present an immediate danger to themselves or others
- Renders the member 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 Dell Children’s Health Plan. 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 Dell Children’s Health Plan concurrent review nurse will implement the concurrent review process to ensure coordination of care.
Fraud, Waste and Abuse

General Obligation to Prevent, Detect and Deter Fraud, Waste and 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 Dell Children’s Health Plan 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 dellchildrenshealthplan.com/providers.

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 you have questions or would like to have more details concerning our fraud, waste and abuse detection, prevention and mitigation program, please contact our chief compliance officer.

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 Dell Children’s Health Plan member identification card. Providers should take measures to ensure the patient is the person named on the card.

Additionally, encourage members to protect their Dell Children’s Health Plan 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 fraud, waste or abuse? Let us know if you think a doctor, dentist, pharmacist at the drug store, other health care providers or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste and/or abuse, 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 Office of Inspector General (OIG) Hotline at 1-800-436-6184.
- Visit [https://oig.hhsc.state.tx.us](https://oig.hhsc.state.tx.us) and select **Click Here to Report Waste, Abuse and Fraud** to complete the online form.
- Report directly to your health plan:

  Attn: Compliance Officer  
  Dell Children’s Health Plan  
  823 Congress Ave., Suite 400  
  Austin, TX 78704
Other reporting options include:
- Dell Children’s Health Plan Provider Services: 1-888-821-1108
- External Anonymous Compliance Hotline: 1-877-660-7890 or amerigroup.silentwhistle.com
- Dell Children’s Health Plan email: corpinvest@amerigroup.com or obe@amerigroup.com

To report fraud, waste or abuse, 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 receives benefits, include:
- The person’s name
- The person’s date of birth, Social Security number or case number (if you have it)
- The city where the person lives
- Specific details about the fraud, waste or abuse

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 www.dshs.state.tx.us/immunize/immtrac/default.shtm.

Laboratory Services (Outpatient)
All outpatient laboratory tests should be performed at a Dell Children’s Health Plan in-network reference lab or a network facility outpatient lab. The exception to this requirement is when the service being performed is a CLIA-approved office test. Visit the CMS website at www.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, precertification is required
for coverage.

**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 a 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 postoperative 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.

**Member Record 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 primary care provider and other providers. Medical
records must be kept in accordance with Dell Children’s Health Plan 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
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 condition.
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 primary care provider’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 primary care providers 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 primary care provider
   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 described in this contract 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 dellchildrenshealthplan.com/providers. 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.

**Member’s Right to Designate an OB/GYN**
Dell Children’s Health Plan allows the member to pick any OB/GYN, whether that doctor is in the same network as the member’s primary care provider or not.

**Attention female members:** Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:
- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

**Noncompliant Dell Children’s Health Plan Members**
Call Provider Services at 1-888-821-1108 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 primary care provider within 30 days of the notice.
- Send a copy of the letter to:
- Continue to provide care to the member until the effective date of the assignment to a new primary care provider.
- 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 Dell Children’s Health Plan. If the member disagrees with the disenrollment, they may access our member complaint process and the HHSC fair hearing process.

Primary Care Providers

Medical Home
The primary care provider is the foundation of the medical home, responsible for providing, managing and coordinating all aspects of the member’s medical care. The primary care provider must provide all care that is within the scope of his or her practice. Additionally, the primary care provider 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 primary care provider is the member’s and family’s initial contact point when accessing health care. The primary care provider 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 primary care provider 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 primary care provider.

Primary Care Provider Types (Network Limitations)
Physicians with the following specialties can apply for enrollment with us as primary care providers:

- 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 primary care provider
• 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 primary care provider before contracting with us for STAR.

Primary Care Provider Responsibilities
The primary care provider 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 primary care providers. 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 by the primary care provider and 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/precertification 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 Dell Children’s Health Plan 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 Dell Children’s Health Plan in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Dell Children’s Health Plan.
• Participate in and cooperate with the Dell Children’s Health Plan complaint procedures; we will notify the primary care provider of any member complaint.
• Not balance-bill members; however, the primary care provider is entitled to collect applicable copayments 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 60 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 Dell Children’s Health Plan quality improvement program initiatives and any related policies and procedures.
• To provide quality care in a cost-effective and reasonable manner.
• Inform Dell Children’s Health Plan 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 nonresearch-related care.
• Inform both Dell Children’s Health Plan and the HHSC administrative services contractor of any changes to the provider’s address, telephone number, group affiliation, etc.

Note: We do not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

After-Hours Coverage
We encourage primary care providers to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, primary care providers must maintain one of the following arrangements for member contact after normal business hours:
• Have the office telephone answered after hours by an answering service that can contact the primary care provider or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must meet the language requirements of the major population groups served.
• Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the primary care provider; the recorded message should direct the member to call another number to reach the primary care provider or another provider designated by the primary care provider; someone must be available to answer the designated provider’s telephone; another recording is not acceptable.
• 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 primary care provider or a designated Dell Children’s Health Plan network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are NOT acceptable:
• Answering office telephone only during office hours
• Answering office telephone after hours by a recording that tells members to leave a message
• Answering 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 primary care provider 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 60 days of the date of enrollment. Other members are encouraged to make an appointment with the primary care provider within 90 calendar days of their effective date of enrollment.

Note: We do not cover the use of any experimental procedures or experimental medications except under certain circumstances.

PCP Changes and Transfers
We encourage members to remain with their primary care providers to maintain continuity of care. However, members may request to change a primary care provider for any reason by contacting Member Services at 1-888-596-0268 (TTY 711). The member’s name will be provided to the primary care provider on the membership roster.

Members can call to request a primary care provider change any day of the month. Primary care provider 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 PCP
Under certain circumstances, a member may require the regular care of the specialist. We may approve that specialist to serve as a member’s primary care provider. The criteria for a specialist to serve as a member’s primary care provider 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 primary care provider; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must:
• Meet the requirements for primary care provider participation (including contractual obligations and credentialing)
• Provide access to care 24 hours a day, 7 days a week
• Coordinate the member’s health care, including preventive care
When such a need is identified, the member or specialist must contact the Dell Children’s Health Plan Case Management department and complete a Specialist as PCP Request form. A case manager 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.

If the request is approved, we will not reduce the compensation that is owed to the original primary care provider before the date of the new designation of the specialist as primary care provider. 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. Specialists serving as primary care providers will continue to be paid fee-for-service while serving as the member’s primary care provider. The designation cannot be retroactive. For more information, call Provider Services at 1-888-821-1108.

Compensation owed to an original primary care provider may not be reduced prior to the effective date of the designation of the specialist as primary care provider.

**Provider Disenrollment Process**

Providers may cease participating with us for either mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death or loss of license. Members are assigned to another primary care provider to ensure continued access to our covered services as appropriate. We will notify members of any termination of primary care providers or other providers from whom they receive ongoing care.

We will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must furnish written notice to us within the time frames specified in the Dell Children’s Health Plan Participating Provider Agreement. Members linked to a primary care provider who disenrolled for voluntary reasons will be notified to select a new primary care provider. We are responsible for submitting notification of all provider disenrollments to the Texas Health and Human Services Commission (HHSC).

**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 [www.hhsc.state.tx.us/Medicaid/Managed-Care/UMCM](http://www.hhsc.state.tx.us/Medicaid/Managed-Care/UMCM).

**Provider Quality Incentive Programs**

We have several provider quality incentive programs to reward primary care providers 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 access measures. Providers must be in good standing and meet the eligibility criteria of the given program to participate. For additional information regarding the programs, call the Provider Relations department.
**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 and/or legally appointed representative, or the member’s primary care provider may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, the options for surgery 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 referral directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the primary care provider will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The primary care provider 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 primary care provider of the results of the second opinion and the consulting provider’s conclusion and recommendation(s) regarding further action.

**Referrals**
Providers shall refer patients to participating providers and facilities when available. 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. We allow members with special health care needs to have direct access to a specialist as appropriate for their conditions and identified needs.

**Specialty Referrals**
To reduce the administrative burden on the provider’s office staff, we have established procedures to permit a member to request an extended authorization. This applies to a member with a condition that requires ongoing care from a specialist physician or other health care provider.

The provider can request an extended authorization by contacting the member’s primary care provider. The provider must supply the necessary clinical information for review by the primary care provider in order to complete the authorization review.
Extended authorizations are approved on a case-by-case basis. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider’s contract with us will apply. The provider may renew the authorization by submitting a new request to the primary care provider. Additionally, we require the specialist physician or other health care provider to furnish regular updates to the member’s primary care provider (unless acting also as the designated primary care provider for the member). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact us for a coverage determination.

If the specialist or other health care provider needed to furnish ongoing care for a specific condition is not available in our network, the referring physician shall request authorization from us for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met. If a provider’s application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through our medical appeal process.

**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 is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a primary care provider, within the network. See the Specialty Care Providers’ Roles and Responsibilities section for more information. In addition to sharing many of the same responsibilities as the primary care provider (see Primary Care Provider Responsibilities), the specialty care provider furnishes services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (e.g., mental health and substance abuse) 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 Providers’ Roles and Responsibilities
Specialist providers will only treat members who have been referred to them by network primary care providers. The exceptions are mental health and substance abuse providers, and services for which a member may self-refer. These providers will render covered services only to the extent and duration indicated on the referral. Obligations of specialists 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 Dell Children’s Health Plan
• Arranging for coverage with network providers while off duty or on vacation
• Verifying member eligibility and precertification of services (if required) at each visit
• Providing consultation summaries or appropriate periodic progress notes to the member’s primary care provider on a timely basis following a referral or routinely scheduled consultative visit
• Notifying the member’s primary care provider when scheduling a hospital admission or any procedure requiring the primary care provider’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 (including those engaged on a FFS basis) to encompass:
  o Monitoring and following up on care provided by other providers
  o Coordinating referrals to other specialists and FFS providers (both in and out-of-network)
  o 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 Dell Children’s Health Plan systems that facilitate record sharing, subject to applicable confidentiality and HIPAA requirements
• Participate in and cooperate with Dell Children’s Health Plan in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Dell Children’s Health Plan
• Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to consumers
• Participate in and cooperate with the Dell Children’s Health Plan 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 60 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 Dell Children’s Health Plan quality improvement program initiatives, and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform Dell Children’s Health Plan 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 nonresearch-related care
- Within 30 days of occurrence, provide written notice to Dell Children’s Health Plan if the specialist is named as a party in any civil, criminal or administrative proceeding; failure to provide timely notice to Dell Children’s Health Plan constitutes grounds for termination of the specialist’s contract with Dell Children’s Health Plan
- 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

Note: We do not cover the use of any experimental procedures or experimental medications except under certain precertified 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.

How to Help a Member Find Dental Care
The dental plan member ID card lists the name and phone number of a member’s main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan’s system, and the member is mailed a new ID card within five business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can call the Medicaid/CHIP enrollment broker’s toll-free telephone number at 1-800-964-2777.

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 fourth to sixth 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 1-888-821-1108.
CHAPTER 14: PHARMACY PROVIDER RESPONSIBILITIES

Overview
Dell Children’s Health Plan has an arrangement with Navitus Health Solutions to administer pharmacy benefits for Dell Children’s Health Plan 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, the preferred drug list, billing, prescription overrides, prior authorizations, quantity limit or formulary exceptions, call Navitus at 1-877-908-6023 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 Medicare Part D services or 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 noncontrolled 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 pharmacy override occurs when Navitus approves a member’s request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. In order to request a pharmacy override, the member or pharmacy should call Navitus at 1-877-908-6023. The following are allowable circumstances for 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 Dell Children’s Health Plan 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, reviewed and approved by the Drug Utilization Review Board. Please refer to the Texas VDP formulary and PDL at [www.txvendordrug.com](http://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, please 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. Venosets, catheters and other medical accessories are not covered and are not included when submitting claims for intravenous and irrigating solutions.

Except for vitamins K and D3, prenatal vitamins, fluoride preparations and products containing iron in its various salts, we do not reimburse for vitamins or legend and nonlegend multiple-ingredient anti-anemia products. 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.

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 Navitus 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
  o Exception: Injectable contraceptives may be dispensed up to a 90-day supply.

You may also verify covered items at [www.navitus.com](http://www.navitus.com) or by calling 1-877-908-6023.

**Specialty Drug Program**
We cover most specialty drugs under the pharmacy benefit. These drugs may be obtained at any network pharmacy that handles these types of drugs.

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
- Nonlegend drugs other than those listed above, or specifically listed under Covered Nonlegend Drugs

Process for Requesting a Prior Authorization
Navitus processes pharmacy prior authorizations (PA) for Dell Children’s Health Plan. The formulary, prior authorization criteria and the length of the prior authorization approval are determined by the Health and Human Services Commission (HHSC). Information regarding the formulary and the specific prior authorization criteria can be found at the Vendor Drug Website, ePocrates and SureScripts for ePrescribing. Prescribers can access prior authorization forms online at www.navitus.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 (prescriber option) and speak with the PA department Monday through Friday, from 8 a.m. and 5 p.m. Central time, to submit a PA request over the phone. After hours, providers will 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 formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.
To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

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

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

Durable Medical Equipment/Other Products Normally Found in a Pharmacy

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

Pharmacies must be enrolled as DME providers and submit claims for most DME to Dell Children’s Health Plan as a medical benefit; however, the durable medical supplies included in VDP’s 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 1-877-908-6023 or via email at providerrelations@navitus.com. For all other DME, the provider must be enrolled in the Dell Children’s Health Plan network by contacting Network Development at shpnetworkdevelopment@seton.org.
Coordination with the Texas Department of Family and Protective Services (DFPS)
The provider 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. The provider 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 Dell Children’s Health Plan. 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).
CHAPTER 16: PROVIDER COMPLAINTS AND APPEALS PROCESS

Provider Complaint Resolution
Dell Children’s Health Plan maintains a system for tracking and resolving provider complaints pertaining to administrative issues and nonpayment-related matters within 30 calendar days of receipt. Dell Children’s Health Plan accepts provider complaints orally or in writing. Written provider complaints should be submitted to:

Attn: Provider Relations
Dell Children’s Health Plan
4515 Seton Center Parkway, Suite 310
Austin, TX 78759
shpproviderservices@seton.org

Dell Children’s Health Plan 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 Dell Children’s Health Plan cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by Dell Children’s Health Plan, that provider may complain to the state. A complaint to the state should be accompanied by all materials related to the complaint (i.e., medical records and the written response from Dell Children’s Health Plan) and a written explanation of the provider’s position on the issue.

STAR complaints may be sent to:

Health Plan Operations
Texas Health and Human Services Commission
Resolution Service H-320
P.O. Box 85200
Austin, TX 78708-5200

CHIP provider complaints are submitted to TDI, rather than HHSC:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Provider Payment Appeals
Dell Children’s Health Plan offers providers a payment appeal resolution process. A payment appeal is any claim payment disagreement between the health care provider and Dell Children’s Health Plan for reason(s), including but not limited to:

- Denials for timely filing
- The failure of Dell Children’s Health Plan to pay timely
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a provider
• Inappropriate or unapproved referrals initiated by providers (i.e., a provider payment appeal may arise if a provider was required to get authorization for a service, did not request the authorization, provided the service and then submitted the claim)
• Provider medical appeals without the member’s consent
• Retrospective review after a claim denial or partial payment
• Request for supporting documentation

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.

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at 1-888-821-1108. Providers will not be penalized for filing a payment appeal. All information will be confidential. The payment appeals team will receive, distribute and coordinate all payment appeals. To submit a payment appeal, please complete the payment appeal form located online at dellchildrenshealthplan.com/providers and submit it to:

Provider Payment Appeals
Dell Children’s Health Plan
P.O. Box 61599
Virginia Beach, VA 23466-1599

A network or non-network provider must file a payment appeal within 120 calendar days of the date of the EOP or for retroactive medical necessity reviews, as of the date of the denial letter. The appeal must be filed by submitting a written request with an explanation of what is being appealed and why. Supporting documentation must be attached to the request. Examples of appropriate supporting documentation include:

• Letter stating the reason(s) why the provider believes the claim reimbursement is incorrect
• Copy of the original claim
• Copy of the Dell Children’s Health Plan 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 date and the name of the Dell Children’s Health Plan person the provider’s staff spoke with when verifying eligibility)
• Medical records
• Approved referral and authorization forms from us indicating the authorization number
• Contract rate sheets indicating evidence of payment rates
• Evidence of previous appeal submission or timely filing
• EDI claim transmission reports indicating that the claim was accepted by Dell Children’s Health Plan
  o Note: Rejection reports are not accepted as proof of timely filing.

Providers may also utilize the payment appeal tool at https://www.availity.com. When inquiring on the status of a claim that is considered eligible for appeal due to no or partial payment, a button will display for submission of an appeal. Once this button is clicked, a web form will display for the provider to
complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the online tool, supporting documentation can be uploaded using the attachment feature on the web payment appeal form. The documentation will attach to the form when submitted.

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 Dell Children’s Health Plan 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.

The results of the review will be communicated in a written decision to the provider within 30 calendar days of the receipt of the appeal. An explanation of payment (EOP) is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. The determination letter includes:

- A statement of the provider’s appeal
- The reviewer’s decision, along with a detailed explanation of the contractual and/or medical basis for such decision
- A description of the evidence or documentation that supports the decision
- A description of the method to obtain a second-level internal review

If a provider is dissatisfied with the Level I payment appeal resolution, he or she may file a Level II payment appeal. This must be a written appeal and must be submitted within 30 days of the date of the Level I determination letter. The case is handled by reviewers not involved in the Level I review. Once the appeal is reviewed, the results will be communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. An EOP is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. 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.

Questions regarding the Dell Children’s Health Plan two-level provider payment appeal process may be directed to Provider Services or a Provider Relations representative.
CHAPTER 17: MEMBER COMPLAINT AND APPEAL PROCESS

Overview
Medicaid and CHIP members (or their representatives) may contact the local member advocate or Member Services for assistance with writing or filing a complaint or appeal (including an expedited appeal).

Definitions
Action: The denial or limited authorization of a requested service, including:
- Type and level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment of service
- Failure to provide services in a timely manner
- Failure of the contractor to act within certain time frames
- Denial of a Medicaid member’s request to exercise his or her right to obtain services outside the network (for a resident of a rural area with only one managed care organization)

Medical appeals are addressed in the Medical Appeal Process and Procedures section of this chapter.

Appeal (Medicaid only): The formal process by which a member or his or her representative request a review of the health plan’s action, as defined above.

Appeal (CHIP program only): The formal process by which a utilization review agent addresses adverse determinations.

Appeellant: Any member or other person or agency designated in writing to act on behalf of the member who files an appeal.

Complainant: Any member (family member or caregiver of a member), provider (treating physician, dentist), or other person or agency designated to act on behalf of the member (including the state’s Medicaid Managed Care Division or the state’s ombudsman program) who files a complaint.

Complaint (CHIP): Any dissatisfaction expressed by a complainant (orally or in writing) to the health plan with any aspect of the health plan’s operation, including but not limited to:
- Plan administration
- Procedures related to review or appeal of an adverse determination
- Denial, reduction or termination of a service for reasons not related to medical necessity
- Service delivery/provision
- Disenrollment decisions

The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP member.

Complaint (Medicaid): An expression of dissatisfaction (orally or in writing) to the health plan about any matter related to the health plan other than an action as defined in this section. Possible subjects for complaints include:
- Quality of care or services provided
• Aspects of patient interaction, such as rudeness of a provider or employee
• Failure of provider or employee(s) to respect a member’s rights

First-level review: Complaints result in a first-level review.

Second-level review: Second-level reviews follow the member’s right to disagree with the decision of a first level review.

Member Complaint Resolution
Complaint process (Medicaid) — the following language or similar information appears in our member handbooks:

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at 1-888-596-0268 (TTY 711) to tell us about your problem. A Dell Children’s Health Plan Member Services representative or a member advocate can help you file a complaint. Just call 1-888-596-0268 (TTY 711). Most of the time, we can help you right away or at the most within a few days.

Can someone from Dell Children’s Health Plan help me file a complaint?
Yes, a member advocate or a Member Services representative can help you file a complaint. Please call Member Services at 1-888-596-0268 (TTY 711).

How long will it take to process my complaint?
Dell Children’s Health Plan will answer your complaint within 30 days from the date we get it.

What are the requirements and time frames for filing a complaint?
You can tell us about your complaint by calling us or writing us. We will send you a letter within five business days of getting your complaint. This means that we have your complaint and have started to look at it. We may call you to get more information.

We will send you a letter within 30 days of when we get your complaint. This letter will tell you what we have done to address your complaint.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Dell Children’s Health Plan complaint process?
If you are a Medicaid member, once you have gone through the Dell Children’s Health Plan 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:

Resolution Services
Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200

If you can get on the internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.
If you file a complaint, Dell Children’s Health Plan will not hold it against you. We will still be here to help you get quality health care.

Complaint Process (CHIP) — the following language or similar information appears in our member handbooks:

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at 1-888-596-0268 (TTY 711) to tell us about your problem. Most of the time, we can help you right away or at the most within a few days.

Can someone from Dell Children’s Health Plan help me file a complaint?
Yes. A Dell Children’s Health Plan Member Services representative or member advocate can help you file a complaint. Just call 1-888-596-0268 (TTY 711).

How long will it take to process my complaint?
We will send you a letter within 30 days of when we get your complaint form. This letter will tell you what we have done to address your complaint. If your complaint is an emergency, we will look into it within 72 hours of getting your call or complaint form.

What are the requirements and time frames for filing a complaint?
Dell Children’s Health Plan will take your complaint over the phone or in writing. Once you make a complaint, we will send you a letter within five business days. This means that we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling 1-800-252-3439 toll-free. If you file or make a complaint, Dell Children’s Health Plan will not and cannot hold it against you. We will still be here to help you get quality health care. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, Texas 78714-9091

If you can get on the internet, you can send your complaint online at www.tdi.texas.gov/consumer/complfrm.html.

Do I have the right to meet with a complaint appeal panel?
Yes, if you are not happy with the answer to your complaint, you can ask us to look at it again. You must let us know in writing. When we receive your request, we will send you a letter within five business days. This means that we have your request and have started to work on it.

We will have a meeting with Dell Children’s Health Plan staff and network providers. We will try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You do not have to come to the meeting. We will send you the papers we will look at during this meeting at least five days before the meeting.
We will send you a letter within 30 days of having this meeting to tell you what the group decides about your complaint.

**Member Medical Appeal Process and Procedures**

Dell Children’s Health Plan has established and maintains a system for resolving dissatisfaction of actions regarding the denial or limitation of coverage of health care services filed by a member or a provider acting on behalf of a member. This process is called a member appeal.

Note: Medical appeals do not apply to nonmedical issues. Nonmedical concerns are classified as complaints.

**Medicaid appeal process** — the following language or similar information appears in our member handbooks:

**What can I do if my doctor asks for a service for me that’s covered but Dell Children’s Health Plan denies it or limits it? How will I find out if services are denied?**

There may be times when Dell Children’s Health Plan says it will not pay for or cover all or part of the care that has been recommended. For example, if you ask for a service that is not covered such as cosmetic surgery, Dell Children’s Health Plan is not allowed to pay for it. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Dell Children’s Health Plan to look again at the care your doctor asked for and we said we will not pay for.

You can appeal our decision in two ways:

- You can call Member Services.
- If you call us, you must still send us your appeal in writing.
  - We will send you an appeal form in the mail after your call.
  - Fill out the appeal form and send it to us within 30 days of when you received your letter telling you we are denying your request to:
    Dell Children’s Health Plan Appeals  
    2505 N. Highway 360, Suite 300  
    Grand Prairie, TX 75050
  - The appeal form must be signed by you or your authorized representative.
  - If you need help filling out the appeal form, please call Member Services.
- You can send us a letter to:
  Dell Children’s Health Plan Appeals  
  2505 N. Highway 360, Suite 300  
  Grand Prairie, TX 75050

**How will I find out if services are denied?**

If we deny coverage, we will send you a letter.

**What are the time frames for the appeals process?**

You or a designated representative can file an appeal. You must do this within 30 days of when you get the first letter from Dell Children’s Health Plan that says we will not pay for or cover all or part of the care that has been recommended.
If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Dell Children’s Health Plan to let us know you have chosen a person to represent you. Dell Children’s Health Plan must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

When we get your letter or call, we will send you a letter within five business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Dell Children’s Health Plan will contact your doctor if we need medical information about this service.

A doctor who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days. If we extend the appeals process, we will let you know the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

**How can I continue receiving my services that were already approved?**
To continue receiving services that have already been approved by Dell Children’s Health Plan but may be part of the reason for your appeal, you must file the appeal on or before the later of:

- 10 days after we mail the notice to you to let you know we will not pay for or cover all or part of the care that has already been approved
- The date the notice says your service will end

If you request that services continue while your appeal is pending, you need to know that you may have to pay for these services.

If the decision on your appeal upholds our first decision, you will be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Dell Children’s Health Plan will pay for the services you received while your appeal was pending.

**Can someone from Dell Children’s Health Plan help me file an appeal?**
Yes, a member advocate or Member Services representative can help you file an appeal. Please call Member Services toll-free at 1-888-596-0268 (TTY 711).

**Can members request a state fair hearing?**
Yes, you can ask for a fair hearing at any time during or after the Dell Children’s Health Plan appeal process unless you have asked for an expedited appeal.

**Process to appeal a CHIP adverse determination** – the following language or similar information appears in our member handbooks:

**What can I do if my child's provider asks for a service for my child that is covered, but Dell Children’s Health Plan denies or limits it?**
There may be times when Dell Children’s Health Plan says it will not pay for care that has been recommended by your provider. If we do this, you, the person acting on your behalf or your child’s provider can appeal the decision. An appeal is when you ask Dell Children’s Health Plan to look again at the care your child’s provider asked for and we said we will not pay for. You must file for an appeal within 30 days from the date on our first letter that says we will not pay for a service.

**How will I find out if services are denied?**
You will receive a letter if you have services that are denied.

**What are the time frames for the appeal process?**
When we get your letter or call, we will send you a letter within five business days. This letter will let you know we got your appeal. A doctor who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal. We have a process to answer your appeal quickly if the care your provider says you need is urgent.

If you are not happy with the answer to your first-level appeal, you can ask your child’s doctor to ask us to look at the appeal again. This is called a second level appeal/specialty review. Your child’s provider must send us a letter to ask for a second level appeal/specialty review within 10 business days of the date on the first level appeal letter from Dell Children’s Health Plan.

When we get the letter asking for the appeal, we will send you a letter within five business days. This letter will let you know we got the letter asking for a second-level appeal/specialty review. A doctor specializing in the type of care your provider says you need will look at the case. We will send you a letter with this doctor’s decision within 15 business days. This letter is our final decision. If you do not agree with our decision, you may ask for an independent review from the state.

**When do I have the right to ask for an appeal?**
You must request an appeal within 30 days from the date on the first letter from Dell Children’s Health Plan that says we will not pay for the service. If you, the person acting on your behalf, or the provider are not happy with the answer to your first-level appeal, the provider must send us a letter to ask for a second-level appeal/specialty review. This letter must be sent within 10 business days from the date on our letter with the answer to your first-level appeal.

If you file a medical appeal, Dell Children’s Health Plan will not hold it against you. We will still be here to help you get quality health care.

**Does my request have to be in writing?**
No. You can request an appeal by calling Member Services at 1-888-596-0268 (TTY 711).

**Can someone from Dell Children’s Health Plan help me file an appeal?**
You can call Member Services at 1-888-596-0268 (TTY 711) if you need help filing an appeal. If you file a medical appeal, Dell Children’s Health Plan will not hold it against you. We will still be here to help you get quality health care.
**Expedited Medical Appeal**

An expedited medical appeal will be performed when appropriate. A member can 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 Dell Children’s Health Plan 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, services, procedure or other health care service that if denied could significantly increase risk to a member’s health or life

**Expedited appeals – the following language or similar information appears in our member handbooks:**

**What is an expedited appeal?**
An expedited appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

**How do I ask for an expedited appeal? Does my request have to be in writing?**
You or the person you ask to file an appeal for you (a designated representative) can request an expedited appeal. You can request an expedited appeal in two ways:

- You can call Member Services at 1-888-596-0268 (TTY 711).
- You can send us a letter to: Dell Children’s Health Plan Appeals, 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050.

**What are the time frames for an expedited appeal?**
After we get your letter or call, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal is about an ongoing emergency or hospital stay, we will call you with an answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within three business days.

**What happens if Dell Children’s Health Plan denies the request for an expedited appeal?**
If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within three calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

If the decision on your expedited appeal upholds our first decision and Dell Children’s Health Plan will not pay for the care your doctor asked for, we will call you and send you a letter to let you know how the decision was made. We will also tell you your rights to request an expedited state fair hearing.

**Who can help me file an expedited appeal?**
A member advocate or Member Services representative can help you file an expedited appeal. Please call Member Services toll-free at 1-888-596-0268 (TTY 711).

CHIP members with a life-threatening condition can request an expedited appeal by an Independent Review Organization without going through the Dell Children’s Health Plan appeal process.
CHIP Independent Review
CHIP members must complete the first level of the Dell Children’s Health Plan 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. 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:

Dell Children’s Health Plan Appeals
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

Independent Review Organization Process — the following language or similar information appears in our member handbooks:

What is an Independent Review Organization?
An Independent Review Organization (IRO) is an organization separate from Dell Children’s Health Plan who can review your appeal. If we have said that we will still not pay for the care after the first-level appeal or specialty review, you, the person acting on your behalf, or the provider can ask for an independent review. With this review, your appeal will be reviewed by an IRO.

How do I ask for a review by an Independent Review Organization?
A request for a review by an IRO form is sent with the first-appeal letter that tells you we will not pay for your care. If you need another one of these forms, just call us. You need to sign and complete this form to ask for an independent review. Mail the form back to us at:

Dell Children’s Health Plan Appeals
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

We will notify the Texas Department of Insurance (TDI) that you have asked for an independent review once we get your form. The TDI will send you a letter that tells you about the IRO who will look at your case. The IRO will send you a letter to tell you its final decision.

What are the time frames for this process?
The IRO will send a letter to you within 20 days of the request for an independent review. In the case of a life-threatening condition, the IRO will contact you with its decision within four business days or less of the request and will issue you a written decision within 48 hours after oral notification is made.

Medicaid State Fair Hearing Information
Can a member ask for a state fair hearing?
If a member, as a member of the health plan, disagrees with the health plan’s decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling Dell Children’s Health Plan the name of the person the member wants to represent him or her. A provider may be the member’s representative. The member or the member’s representative must ask for the fair hearing within 90 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 fair hearing within 90 days, the member may lose his or her right to a fair hearing.
To ask for a fair hearing, the member or the member’s representative should send a letter to the health plan at:

Fair Hearing Coordinator
Dell Children’s Health Plan
3800 Buffalo Speedway, Suite 400
Houston, TX 77098

The member may also call Member Services at 1-888-596-0268 (TTY 711).

The member has the right to keep getting any service the health plan denied or reduced at least until the final hearing decision is made, if the member asks for a fair hearing by the latter of:

- 10 calendar days following the Dell Children’s Health Plan mailing of the notice of the action
- The day the health plan’s letter says the service will be reduced or end

If the member does not request a fair hearing by this date, the service the health plan denied will be stopped.

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

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

Medicaid Continuation of Benefits
Dell Children’s Health Plan Medicaid members may request a continuation of their benefits during the medical appeal process by contacting Dell Children’s Health Plan Member Services at 1-888-596-0268 (TTY 711). To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file a medical appeal on or before 10 calendar days following the Dell Children’s Health Plan mail date of the notice of action or the intended effective date of the action.

Dell Children’s Health Plan will continue the member’s coverage of benefits if the following conditions are met:

- The member or the provider files the appeal timely (as defined above).
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the initial authorization has not expired.
- The member requests an extension of benefits.

If, at the member’s request, Dell Children’s Health Plan continues or reinstates the benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the medical appeal or request for the state fair hearing.
- The designated calendar days pass after Dell Children’s Health Plan mails the medical appeal determination letter unless the member has, within the 10 calendar days, requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- The time period or service limits of a previously authorized service has been met.
The member may be responsible for the continued benefits if the final determination of the medical appeal is not in his or her favor. If the final determination of the medical appeal is in the member’s favor, Dell Children’s Health Plan will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member’s health condition requires. If the final determination is in the member’s favor and the member received the disputed services, Dell Children’s Health Plan will pay for those services.
CHAPTER 18: MEMBER ELIGIBILITY

Overview
HHSC determines Medicaid and CHIP eligibility and notifies the enrollment broker. The enrollment broker then provides information to the Medicaid or CHIP recipient on the available health plans in the member’s service area. The member has to choose a health plan and enroll through the enrollment broker. Medicaid recipients under the age of 21 are eligible to receive services under the Texas Health Steps program. Dell Children’s Health Plan will ensure that members are provided information and educational materials about the services available through the Texas Health Steps program, and how and when they can obtain the services.

Additionally, Dell Children’s Health Plan will educate members about the importance of regularly scheduled Texas Health Steps medical checkups and developing a relationship with their PCP within the first 90 days of enrollment.

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

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

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

We encourage all providers to verify eligibility and benefits before each service is rendered. Please call Dell Children’s Health Plan Provider Services at 1-888-821-1108 or log on to our secure provider website to look up claims status, eligibility and authorizations at https://www.availity.com.

“Your Texas Benefits” Medicaid Card
Your Texas Benefits Medicaid ID Card Sample:
**Dell Children’s Health Plan ID Card Sample:**

A person approved for Medicaid will get a Your Texas Benefits Medicaid card. The plastic card has a magnetic stripe that holds the member’s Medicaid ID number. 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 at 1-855-827-3748.

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)
  - Texas Women’s Health Program (TWHP)
  - 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 ([www.yourtexasbenefits.com](http://www.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.

**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 Dell Children’s Health Plan-assigned number effective on his or her date of birth.

**CHIP**

Dependent upon the member’s CHIP category, the copayments 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.

**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.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborns</td>
<td>We are responsible for coverage of all covered services for 90 days after birth, including hospital, provider and nonhospital services costs attributed to the care of a newborn, if the mother was enrolled with Dell Children's Health Plan on the date of birth.</td>
</tr>
<tr>
<td>Hospital Transfers</td>
<td>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.</td>
</tr>
<tr>
<td>Inpatient Psychiatric Care</td>
<td>We are responsible for payment of all covered provider services from the member’s date of enrollment.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant members (including pregnant teens)</td>
<td>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</td>
</tr>
<tr>
<td>Newborns</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

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 Perinatal 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 Perinatal newborn members. Copayments/cost sharing does not apply to CHIP Perinate mothers or CHIP Perinate newborns.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families with income at or below the Medicaid eligibility threshold</td>
<td>Dell Children’s Health Plan 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 &amp; Healthcare Partnership for processing.</td>
</tr>
<tr>
<td>Families with income above the Medicaid eligibility threshold</td>
<td>Dell Children’s Health Plan 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.</td>
</tr>
</tbody>
</table>

Member Enrollment and Disenrollment from Dell Children’s Health Plan

Medicaid Enrollment

STAR members may enroll in, or disenroll from, Dell Children’s Health Plan at any time. If a member asks how to enroll in, or disenroll from, Dell Children’s Health Plan, 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: P.O. 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:

<table>
<thead>
<tr>
<th>Certification Date</th>
<th>Enrollment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified from the 1st through the 10th of the month</td>
<td>Member will be enrolled on the first day of the month of certification.</td>
</tr>
<tr>
<td>Certified from the 11th through the end of the month</td>
<td>Member will be enrolled on the first day of the month following the month of certification.</td>
</tr>
<tr>
<td>Certified at any time during their estimated month of delivery</td>
<td>Member will be enrolled the first day of the following month (prospective enrollment).</td>
</tr>
<tr>
<td>Certified in their actual month of delivery (if known by the Department of State Health Services prior to certification)</td>
<td>Member will be enrolled the first day of the following month (prospective enrollment).</td>
</tr>
</tbody>
</table>

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 HMO. The member may elect to change HMOs at any time. Temporary loss of eligibility is defined as a period of six 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 FFS require medical documentation from the primary care provider 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 Dell Children’s Health Plan.

Medicaid Enrollment Changes During an Inpatient Stay in a Hospital
The following table describes payment responsibility for Medicaid enrollment changes that occur during an inpatient stay in a hospital, 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 Texas Medicaid Provider Procedures Manual (TMPPM).

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Hospital Facility Charge</th>
<th>All Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member retroactively enrolled in STAR, STAR+PLUS or Dual Demonstration</td>
<td>New MCO</td>
<td>New MCO</td>
</tr>
<tr>
<td>Member prospectively moves from FFS to STAR, STAR+PLUS or Dual Demonstration</td>
<td>Medicaid FFS</td>
<td>New MCO</td>
</tr>
<tr>
<td>Scenario</td>
<td>Hospital Facility Charge</td>
<td>All Other Covered Services</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Member moves from STAR to FFS (disenrolled at MCO’s request)</td>
<td>Former STAR MCO</td>
<td>Medicaid FFS</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>CDTF Charge</th>
<th>All Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member retroactively enrolled in STAR</td>
<td>New MCO</td>
<td>New MCO</td>
</tr>
<tr>
<td>Member prospectively moves from FFS to STAR</td>
<td>New MCO</td>
<td>New MCO</td>
</tr>
<tr>
<td>Member moves between STAR MCOs</td>
<td>Former MCO</td>
<td>New MCO</td>
</tr>
<tr>
<td>Member moves from STAR to STAR Health</td>
<td>Former STAR MCO</td>
<td>New STAR Health MCO</td>
</tr>
<tr>
<td>Adult member moves from STAR Health to STAR</td>
<td>Former STAR Health MCO</td>
<td>New STAR MCO</td>
</tr>
<tr>
<td>Member moves from STAR to STAR+PLUS or Dual Demonstration (based on change in SSI status)</td>
<td>Former STAR MCO</td>
<td>New STAR+PLUS or Dual Demonstration MCO</td>
</tr>
</tbody>
</table>

**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.
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.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Custom DME</th>
<th>All Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member moves between STAR, STAR+PLUS, or STAR Health MCOs</td>
<td>Former MCO</td>
<td>New MCO</td>
</tr>
<tr>
<td>Member moves from FFS to STAR, STAR+PLUS, or STAR Health MCO</td>
<td>New MCO</td>
<td>New MCO</td>
</tr>
</tbody>
</table>

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 Dell Children’s Health Plan. HHSC will notify Dell Children’s Health Plan 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 Dell Children’s Health Plan Member Services at 1-888-596-0268 (TTY 711) or CHIP at 211.

Dell Children’s Health Plan 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 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 Perinatal 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 Perinatal 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.

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 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 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.

In the tenth 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 that is prepopulated to include the CHIP Perinate newborn’s and the CHIP member’s information.

CHIP Perinatal members may request to change health plans for any reason within 90 days of enrollment in the CHIP Perinatal 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 Perinatal. Providers cannot take retaliatory action against a member who decides to disenroll from the CHIP Perinatal program.

Enrollments and Disenrollments While Hospital Confined
If a CHIP Program or CHIP Perinatal member’s effective date of coverage occurs while the member is confined in a hospital, Dell Children’s Health Plan 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, Dell Children’s Health Plan’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 Medicaid FFS (if the member is a child), or a prospective move to STAR+PLUS (if the member is a child or adult).

HHSC will not retroactively disenroll a member from the STAR, CHIP or CHIP Perinatal programs.
Medicaid Member Rights and Responsibilities

STAR Member Rights

The following language or similar information appears in our member handbooks:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect
   b. Know that your medical records and discussions with your providers will be kept private and confidential

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan
   c. Change your primary care provider
   d. Change your health plan without penalty
   e. Be told how to change your health plan or your primary care provider

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
   b. Be told why care or services were denied and not given

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you
   b. Say yes or no to the care recommended by your provider

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints appeals and fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan
   b. Get a timely answer to your complaint
   c. Use the plan’s appeal process and be told how to use it
   d. Ask for a fair hearing from the state Medicaid program and get information about how that process works

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need
   b. Get medical care in a timely manner
   c. Be able to get in and out of a health care provider’s office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act
d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability or help you understand the information
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them

7. You have the right to not be restrained or secluded when it is for someone else’s convenience or is meant to force you to do something you do not want to do or is to punish you.

8. You have a right to know that doctors, hospitals and others who care for you can advise you about your health status, medical care and treatment; your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

**STAR Member Responsibilities**

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program
   b. Ask questions if you do not understand your rights
   c. Learn what choices of health plans are available in your area

2. You must abide by the health plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan’s rules and Medicaid rules
   b. Choose your health plan and primary care provider quickly
   c. Make any changes in your health plan and primary care provider in ways established by Medicaid and by the health plan
   d. Keep your scheduled appointments
   e. Cancel appointments in advance when you cannot keep them
   f. Always contact your primary care provider first for your nonemergency medical needs
   g. Be sure you have the approval from your primary care provider before going to a specialist
   h. Understand when you should and should not go to the emergency room

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated
   c. Help your providers get your medical records

4. You must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you
   b. Understand how the things you do can affect your health
   c. Do the best you can to stay healthy
   d. Treat providers and staff with respect
   e. Talk to your provider about all of your medications

**CHIP Member Rights and Responsibilities**

The following language or similar information appears in our member handbooks:
CHIP Member Rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child’s health plan, doctors, hospitals and other providers.

2. Your health plan must tell you if they use a limited provider network. This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Limited provider network means you cannot see all the doctors who are in your health plan. If your health plan uses limited networks, you should check to see that your child’s primary care provider and any specialist doctor you might like to see are part of the same limited network.

3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child’s primary care provider. Ask your health plan about this.

8. Children who are diagnosed with special health care needs or a disability have the right to special care.

9. If your child has special medical problems and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating OB/GYN without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child’s life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment, depending on your income. Copayments do not apply to CHIP Perinatal members.

12. You have the right and responsibility to take part in all the choices about your child’s health care.

13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.

16. You have the right to talk to your child’s doctors and other providers in private, and to have your child’s medical records kept private. You have the right to look over and copy your child’s medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan’s doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

18. You have a right to know that doctors, hospitals and others who care for your child can advise you about your child’s health status, medical care and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals and others cannot require you to pay any other amounts for covered services.

CHIP Member Responsibilities
You and your health plan both have an interest in seeing your child’s health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor’s decisions about your child’s treatments.
3. You must work together with your health plan’s doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan’s complaint process.
5. You must learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
6. If you make the appointment for your child, you must try to get to the doctor’s office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers the copayments you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members or health plans.
9. Talk to your child’s provider about all of your child’s medications.

CHIP Perinatal Member Rights and Responsibilities
The following language or similar information appears in our member handbooks:

CHIP Perinatal 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 Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child’s life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child’s health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to your perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.

11. You have the right to a fair and quick process for solving problems with the health plan and the health 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.

CHIP Perinatal Member Responsibilities
You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor’s decisions about your unborn child’s care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan’s complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal member handbook to understand how the rules work.
5. You must try to get to the doctor’s office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members or health plans.
7. Talk to your provider about all of your medications.

Member’s Right to Designate an Obstetrician/Gynecologist
Our members are informed of their right to select an Obstetrician/Gynecologist (OB/GYN) without a referral from their primary care provider. Our members may access the health services of an OB/GYN for their annual well-woman exam, prenatal care, female medical conditions and specialist referrals within the network.

The following language or similar information appears in our member handbooks:

Do I have the right to choose an OB/GYN?
You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to a specialist doctor within the network
CHAPTER 20: BILLING AND CLAIMS ADMINISTRATION

Overview
Providers have three options for submitting claims to us:
- Electronic Data Interchange (EDI)
- On the Availity Web Portal at https://www.availity.com
- 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 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 one 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. We edit claims using SNIP Level 5 and 6 edits.

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 dellchildrenshealthplan.com/providers.

International Classification of Diseases, 10th Revision (ICD-10) Description
As of October 1, 2015, ICD-10 became 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 replaces 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 the MCO or its subcontracted claims processor 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:

a. 837 Professional Combined Implementation Guide
b. 837 Institutional Combined Implementation Guide
c. 837 Professional Companion Guide
d. 837 Institutional Companion Guide

Note: Additional clean claim definitions are provided in 21 TAC 21.2803.

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

**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/precertification number or copy of authorization/precertification
- 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.

Clean claims are adjudicated within 30 calendar days of receipt (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 Dell Children’s Health Plan 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**

**Electronic Data Interchange Submission**
We encourage electronic submission of claims through Electronic Data Interchange (EDI). Electronic claims submission is available through:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Dell Children’s Health Plan Payer ID</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Healthcare (Emdeon)</td>
<td>74272</td>
<td>1-866-858-8938</td>
</tr>
<tr>
<td>Availity</td>
<td>DCHPMCAID</td>
<td>1-800-282-4548</td>
</tr>
<tr>
<td>Smart Data Solutions</td>
<td>27182</td>
<td>1-855-650-6590</td>
</tr>
</tbody>
</table>

The guide for EDI claims submission is located on our website at dellchildrenshealthplan.com/providers. The guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or to obtain additional information, please call the Dell Children’s Health Plan EDI Hotline at 1-800-590-5745.
Providers must complete the *Trading Partner Agreement* before submitting claims by a batch 837 file. To find the trading partner agreement, visit our website at [dellchildrenshealthplan.com/providers]. Once you complete the agreement, fax the form to our EDI department at 757-226-7469. Upon receipt of the form, a member of the EDI team will review it and follow up with you to initiate the process for allowing batch submissions.

**Online Claims Submission**

We offer a free online claim submission tool for all providers at [https://www.availity.com](https://www.availity.com). This tool submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration.

**Paper Claims Submission**

We accept paper claim submissions through 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 [www.cms.hhs.gov](http://www.cms.hhs.gov).

We use optical character recognition (OCR) technology as part of our front-end claims processing procedures. Claims must be submitted on original red claim forms (not black and white or photocopied forms) with laser printed or typed (not handwritten) information in a large, dark font. We cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return. We will not accept handwritten claims.

Submit paper claims to:

Texas Claims  
Dell Children’s Health Plan  
P.O. Box 61010  
Virginia Beach, VA 23466-1010

**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.
- Any claim with charges that meet or exceed $5,000.

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:

Dell Children’s Health Plan  
Box 61010  
Virginia Beach, VA 23466-1010

**Claims Status**

We offer two methods for accessing claim status 24 hours a day, 365 days a year:

- The Availity Web Portal at [https://www.availity.com](https://www.availity.com)
- The Provider Inquiry Line at 1-888-821-1108

**Capitation**

Providers contracted under capitated reimbursement methodologies receive payment on a per-member-per-month 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.

**Provider Reimbursement**

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

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 the state agencies responsible for provider enrollment, either TMHP or DADS for long-term services and supports providers.

**EDI Claims Submissions (837)**

Get paid faster and submit more accurate claims using Electronic Data Interchange (EDI). Contact one of the clearinghouses listed below and they will assist with submitting claims to Dell Children’s Health Plan.*

Here are the clearinghouses we work with and how to contact them:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Payer ID</th>
<th>For more information, call:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emdeon</td>
<td>74272</td>
<td>1-866-858-8938</td>
</tr>
<tr>
<td>Availity</td>
<td>DCHPMCAID</td>
<td>1-800-282-4548</td>
</tr>
<tr>
<td>Smart Data Solutions</td>
<td>27182</td>
<td>1-855-650-6590</td>
</tr>
</tbody>
</table>

Call the EDI Hotline at 1-800-590-5745 and speak to an EDI Helpdesk technician for further assistance.

**Electronic Funds Transfer and Electronic Remittance Advice**

We offer 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


**Primary Care Provider Reimbursement**

We reimburse primary care providers according to their contractual arrangement.

**Specialist Reimbursement**

Reimbursement to network specialty care providers and network providers not serving as primary care providers is based on their contractual arrangement with us.

Specialty care providers will obtain primary care provider and Dell Children’s Health Plan approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the primary
care provider’s referral. This also applies to treatment that is beyond the scope of self-referral permitted under the program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification. We must be in receipt of the required claims and encounter information.

**Overpayments**

We are entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us. Overpayments may be identified by our Cost Containment Unit (CCU), a Dell Children’s Health Plan vendor or the provider. When an overpayment is identified by the CCU or a Dell Children’s Health Plan vendor, the provider will receive written notification. The notification will include a *Refund Notification Form* specifying the reason for the return, to be completed by the provider and returned along with the refund check. This form can be found on our provider website at [dellchildrenshealthplan.com/providers](http://dellchildrenshealthplan.com/providers). The submission of the *Refund Notification Form* allows us to process and reconcile the overpayment in a timely manner. 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.

**Provider-Preventable Conditions**

We are 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 Dell Children’s Health Plan, including hospital lists, effective dates and reduction data. We apply those reductions for each hospital on the report including behavioral health hospitals. Dell Children’s Health Plan 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 two 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 two-year period following receipt of the claim. In addition, the two-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 two years after we received the claim. Also, the two-year limitation does not apply when HHSC has recovered a capitation from us based on a member’s
ineligibility. If any exception to the two-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.

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 Dell Children’s Health Plan Medicaid members for a third-party insurance copayment. 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 Agreement**

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 Dell Children’s Health Plan 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 Dell Children’s Health Plan for services provided to me.”

______________________________  ______________________
Signed  Date

**Member Acknowledgment Statement**

Providers may bill a Dell Children’s Health Plan member for a service denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

- The member requests the specific service or item.
- 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.
Client Acknowledgment Statement Form

I understand my doctor, ______________________, or Dell Children’s Health Plan has said the services or items I have asked for on __________________________, are not covered under my plan. Dell Children’s Health Plan will not pay for these services. Dell Children’s Health Plan 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 Dell Children’s Health Plan 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.

______________________________________________  Date: __________________
Member name (print)

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.

______________________________________________  Date: __________________
Provider name (print)

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 copayments and premiums. Cost-sharing guidelines include:

- Information about copayments and annual reporting caps is based on family income; the CHIP member ID card shows the member’s copayment 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 copayment is collected from the member for the balance of the year.

Cost-sharing guidelines require that providers:

- Only bill for valid, unpaid copayments and noncovered services received by the member.
- Promptly refund member overpayments if an incorrect copayment was collected for covered services.
- Not collect additional payment once the copayment is made.
- Verify eligibility and copayment amounts by calling Provider Services at 1-888-821-1108.

Cost-sharing exemptions include:

- Preventive health care services, such as well-child exams and immunizations and pregnancy-related services are exempt.
- Enrollment fees and copayments do not apply for Native Americans, Alaskan Natives, CHIP Perinates and CHIP Perinate newborn members.
- Copayments may not be collected in excess of the cost of a covered service.

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

CHIP Cost-Sharing Schedule
Copayment information is shown in the table below:

<table>
<thead>
<tr>
<th>CHIP Cost Sharing</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment Fees (for 12-month enrollment period)</strong></td>
<td></td>
</tr>
<tr>
<td>At or below 150 percent of FPL</td>
<td>$0</td>
</tr>
<tr>
<td>Above 150 percent up to and including 185 percent of FPL</td>
<td>$35</td>
</tr>
<tr>
<td>Above 185 percent up to and including 200 percent of FPL</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Copays (per visit):</strong></td>
<td></td>
</tr>
<tr>
<td>At or below 100 percent of FPL</td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>$3</td>
</tr>
<tr>
<td>Nonemergency ER</td>
<td>$3</td>
</tr>
<tr>
<td>Generic drug</td>
<td>$0</td>
</tr>
<tr>
<td>Brand drug</td>
<td>$3</td>
</tr>
<tr>
<td>Facility copay, inpatient</td>
<td>$15</td>
</tr>
<tr>
<td>Cost-sharing cap</td>
<td>5% (of family’s income)</td>
</tr>
<tr>
<td><strong>Above 100 percent up to and including 150 percent of FPL</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHIP Cost Sharing

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>$5</td>
</tr>
<tr>
<td>Nonemergency ER</td>
<td>$5</td>
</tr>
<tr>
<td>Generic drug</td>
<td>$0</td>
</tr>
<tr>
<td>Brand drug</td>
<td>$5</td>
</tr>
<tr>
<td>Facility copay, inpatient</td>
<td>$35</td>
</tr>
<tr>
<td>Cost-sharing cap</td>
<td>5% (of family’s income)²</td>
</tr>
</tbody>
</table>

Above 150 percent up to and including 185 percent of FPL

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>$20</td>
</tr>
<tr>
<td>Nonemergency ER</td>
<td>$75</td>
</tr>
<tr>
<td>Generic drug</td>
<td>$10</td>
</tr>
<tr>
<td>Brand drug</td>
<td>$35</td>
</tr>
<tr>
<td>Facility copay, inpatient</td>
<td>$75</td>
</tr>
<tr>
<td>Cost-sharing cap</td>
<td>5% (of family’s income)²</td>
</tr>
</tbody>
</table>

Above 185 percent up to and including 200 percent of FPL

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>$25</td>
</tr>
<tr>
<td>Nonemergency ER</td>
<td>$75</td>
</tr>
<tr>
<td>Generic drug</td>
<td>$10</td>
</tr>
<tr>
<td>Brand drug</td>
<td>$35</td>
</tr>
<tr>
<td>Facility copay, inpatient</td>
<td>$125</td>
</tr>
<tr>
<td>Cost-sharing cap</td>
<td>5% (of family’s income)²</td>
</tr>
</tbody>
</table>

1 The Federal Poverty Level (FPL) refers to income guidelines established annually by the federal government.
2 Per 12-month term of coverage.

Note: CHIP members are required to pay office-visit copay for each nonpreventive dental visit.

CHIP Perinatal Postpartum Billing

As the mother’s eligibility expires after delivery, claims received for postpartum services will be denied. Though these claims will always be denied, a provider should still submit them because he or she may be eligible for an incentive fee for reporting these encounters. To ensure receipt of the reporting fee, the codes listed below must be used to report postpartum care. Providers will bill postpartum visits as follows:

- CPT code 59430 (postpartum care only)
- DX code Z39.2 (postpartum care only)

Emergency Services

Precertification is not required for coverage of emergency services. Any hospital or provider request for authorization of emergency services is granted immediately. 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.

Special Billing

When billing a newborn claim, use the newborn’s Medicaid ID. If no ID has been assigned yet, call us at 1-888-821-1108 for assistance. Do not submit a claim under the mother’s global ID.

Provider Payment Appeals

Information on the payment appeal process, including acute care claims, is located in the Provider Complaints and Appeals Process chapter.
Out-of-Network Providers

Claims Submission
Nonparticipating providers located in Texas must submit clean claims to us within 95 days of service. Nonparticipating providers located outside of Texas must submit clean claims to us within 365 days of the date of service. Refer to the definition of clean claim in the Billing and Claims Administration chapter of this provider manual. To submit claims for services provided to Medicaid (STAR) members, providers must have an active Texas provider identifier on file with TMHP, the state’s contracted administrator.

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

Reimbursement
Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For Medicaid (STAR) we reimburse:
- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less five percent
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate

For CHIP, we allow for reimbursement at the usual and customary rate.