801 Seventh Avenue
Fort Worth, Texas 76104-2796
888-243-3312
cookchp.org

STAR•CHIP
CHIP Perinatal
Provider Manual

Tarrant Service Area
Denton, Hood, Johnson, Parker, Tarrant, Wise

June 2023

Introduction

Welcome to Cook Children's Health Plan. Thank you for joining one of the most established and respected healthcare systems in the southwest. As a valued partner in our network, we will work together to deliver an inspiring ***Promise –knowing every child's life is sacred, we promise to improve the well-being of every child in our care and communities.***

Childhood is simple, until it isn't. When things get complicated, Cook Children's is here to help. Our Provider Manual will serve as a useful reference when working with Cook Children's Health Plan and with our shared Members who receive services through the Texas Health and Human Services Commission STAR and CHIP/CHIP Perinatal program.

Background

Over century ago, the first children's hospital in Fort Worth opened with 30 beds and a promise to provide every child in the area access to medical care. From these humble beginnings Cook Children's has grown to become one of the country's leading integrated pediatric health care systems.

Based in Fort Worth, Texas, we're proud of our long and rich tradition of serving our community. For over 100 years we've worked to improve the health of children from across our primary service area of Denton, Hood, Johnson, Parker, Tarrant and Wise counties. We combine the art of caring with leading technology and extraordinary collaboration to provide exceptional care for every child. This has earned Cook Children's a strong, far reaching reputation with patients traveling from around the country and the globe to receive lifesaving pediatric care.

Our not-for-profit organization is comprised of eight companies, including our Medical Center, Physician Network, Home Health Company, Pediatric Surgery Center, Health Plan, Health Services Inc. and Health Foundation. With more than 60 primary, specialty and urgent care locations throughout Texas, families can access our top-ranked specialty programs and network of services to meet the unique needs of their child.

Cook Children's Health Plan

Since 1998 Cook Children's Health Plan has provided essential coverage to low-income families in our six-county service area who qualify for government-sponsored programs, including Medicaid STAR and CHIP. Enrollment in Medicaid and CHIP has grown to more than 120,000 Members, including children and expectant mothers. Members receiving services associated with STAR and CHIP are supported by a Plan network of more than 570 doctors, more than 1,300 specialists and 43 hospitals. In November 2016, STAR Kids

was integrated into Cook Children's Health Plan.

Objective of Program

Cook Children's Health Plan is committed to providing services for children with disabilities who have Medicaid coverage to:

- Improve coordination and customization of care
- Access to care
- Improve health outcomes
- Improve quality of care
- Continually strive to improve both Member and Provider satisfaction.

Quick Reference Phone Guide

Quick Reference Topic	Description
General Correspondence Address	Cook Children's Health Plan P.O. Box 2488 Fort Worth, TX 76113-2488 Website: cookchp.org
Member Services Telecommunication Device for the Deaf (TTY/TDD for deaf or hearing impaired)	For Verification of Eligibility and Benefits Toll Free: 888-243-3312 Fax : 682-885-8401 Email: CCHPCustomerScv@cookchildrens.org TTY/TDD: 682-885-2138 TTY/TDD toll free: 844-644-4137 Our representatives speak English and Spanish to help you. We have an interpreter service that can help with other languages.
Care Management	For Prior Authorizations, Medical Necessity Denials & Appeals, Case Management, Baby Steps Program, and Disease Management: Toll Free: 888-243-3312 TTY/TDD: 682-885-2138 TTY/TDD toll free: 844-644-4137 STAR/CHIP Fax: 682-885-8402 STAR/CHIP Toll Free Fax: 844-346-8402 Email: CCHPPriorAuthorizations@cookchp.org Our representatives are available 8 a.m. to 5 p.m., Monday to Friday, except for state holidays. Interpreter services and TTY/TDD are available for Utilization Management questions. For Emergencies after hours/weekends, Members should call 9-1-1 or go to the nearest emergency department. If the member is experiencing a behavioral health crisis call 833-391-3733 (crisis line number available 24 hours 7 days a week). If the call is not an emergency, leave a message and your call will be returned the next

	business day Pharmacy assistance is available 8 a.m. to 5 p.m., Monday to Friday, except for state holidays.
Claims and Billing	For Claim Status, Payment Inquiries, and Claim Appeals: Toll Free: 888-243-3312 Fax Number: 682-885-8804 To submit Paper Claims: Cook Children's Health Plan Attention: Claims Department PO Box 21271 Eagan, MN. 55121-0271 To submit Appeals: Cook Children's Health Plan Attention: Claims Department PO Box 2488 Fort Worth, TX 76113-2488 Fax: 682-885-8404
Compliance	Member and Provider Complaints, or to Report Fraud, Waste and Abuse: Toll Free: 888-243-3312 Fax: 682-303-0276 Email: CCHPCompliance@cookchildrens.org
Network Development	For Credentialing, Contracting, Provider Demographic Updates and Changes: Toll Free: 888-243-3312 Fax: 682-885-8403 Email: CCHPNetworkDevelopment@cookchildrens.org

Outreach	Questions about Migrant Farm Workers, Texas Health Steps and Well Child Appointments: Toll Free: 888-243-3312 Fax Number: 682-303-2244 Email: OutreachCCHP@cookchildrens.org
Provider Relations	Provider Education and Training: Toll Free: 888-243-3312 Fax Number: 682-885-8436 Email: CCHPProviderRelations@cookchildrens.org
Vision Services National Vision Administrators (NVA)	Toll Free: 888-830-5630 Fax: 888-830-5560 Email: providers@e-nva.com
Pharmacy Navitus Help Desk	Toll Free: 877-908-6023 Fax: 866-808-4649 Email: ProviderRelations@navitus.com Website: Navitus.com
Dental Services DentaQuest: MCNA: United Healthcare Dental:	 Toll Free: 800-516-0165 Toll Free: 855-691-6262 Toll Free: 877-901-7321
Dental Value Add – Liberty Dental	Toll Free: 888-902-0349 TTD/TTY: 866-222-4306
Nurse Advice Line	Toll Free: 866-971-2665
Childhood Lead Poisoning Prevention/DSHS	Main: 512-458-7151
Comprehensive Care Program/TMHP	Toll Free: 800-925-9126
Critical Incident Reporting	Fax: 682-885-8494 Email: CCHPQualityImprovement@cookchildrens.org

Department of Assistive and Rehabilitative Services (DARS) Inquiries	Toll Free: 800-628-5115
Department of Family and Protective Services (DFPS)	Toll Free: 800-252-5400
Early Childhood Intervention (ECI)	Toll Free: 800-628-5115
Family Planning Program	Main: 512-458-7796
HHSC Help Line (Members)	Toll Free: 800-252-8263
HHSC Vendor Drug Services (Providers only)	Toll Free: 800-435-4165
Maximus – Enrollment Broker	Toll Free: 877-782-6440
Medical Transportation Program (MTP)	Toll Free: 877-633-8747
Office of the Inspector General Hotline (OIG)	Medicaid Fraud & Abuse Toll Free: 800-436-6184
Texas CHIP Program Helpline	Toll Free: 800-647-6558
Texas Health Steps Program	Toll Free: 877-847-8377
Texas Medicaid Managed Care Helpline	Ombudsman Managed Care Assistance Team Toll Free: 866-566-8989 TTD/TTY: 866-222-4306
Texas Medicaid and Healthcare Partnership (TMHP)	Toll Free: 800-925-9126 Toll Free: 888-863-3638 Website: tmhp.com

Texas Vaccines for Children Program (TVFC)	Toll Free: 800-252-9152
To enroll as a Texas Health Steps Provider, call TMHP	Toll Free: 800-925-9126 Website: tmhp.com
Women, Infants, and Children (WIC) Nutrition Program	Toll Free: 800-942-3678

Table of Contents

Section 1: Provider Responsibilities

Primary Care Provider Responsibilities

Role of the Primary Care Provider

Primary Care Providers (PCP) are responsible for furnishing all Primary Care related services within the scope of the Provider's practice and are responsible for arranging and coordinating all health care services required by the Member. STAR, CHIP, CHIP Perinate Primary Care Providers in the Cook Children's Health Plan network are located in the and around the following counties: Tarrant, Wise, Johnson, Parker, Hood and Denton.

The following Provider types may serve as Primary Care Providers:

- Family/General Practice
- Pediatricians
- Internal Medicine
- Obstetrics/Gynecologists (OB/GYN)
- Advanced Practice Nurses – (when practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/ Gynecology)
- Certified Nurse Midwives (CNM) – (When practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics, or Obstetrics/Gynecology
- Physician Assistants (PAs) – (when practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Community Clinics
- Specialist Physicians – (who are willing to provide a medical home to selected Members with special needs and conditions)

Primary Care Provider Medical Home Responsibilities

A Primary Care Provider must assess the medical and behavioral health needs of Members for referral to Specialty Care Providers (SCP), provide referral care as needed, coordinate the Member's care with Specialty Providers after the referral, and serve as a Medical Home to Members. The Medical Home concept establishes a relationship between the Primary Care Physician and the patient in which the physician provides comprehensive primary care to the patient and facilitates partnerships between the physicians, patient, acute care

and other care Providers when appropriate.

Through the medical home the Member has an ongoing relationship with the physician who is trained to be the first contact for the Member and to provide continuous and comprehensive care. The physician is responsible for providing all of the care the Member needs or for coordinating with other qualified Providers to provide care including preventative care, acute care, chronic care and end of life care.

Primary Care Providers who provide covered services for Medicaid (STAR) and CHIP newborns must either have admitting privileges at a hospital that is part of the Cook Children's Health Plan network or make referral arrangements with an in network Provider who has admitting privileges to a network hospital.

Specialty Care Provider Responsibilities

Role of the Specialty Care Provider

The Specialty Care Provider provides diagnostic treatments and/or management options, tests and treatment plans, as requested by the Primary Care Provider. Primary Care and Specialty Care Providers shall work together to maintain ongoing communication regarding the Member's care and treatment. Specialty Care Providers shall maintain regular hours of operation that are clearly defined and communicated to Members. Such access shall include regular office hours on weekdays and call coverage twenty-four hours a day. Treatment for urgent specialty care services must be provided within twenty-four hours of the request.

Specialist as a Primary Care Provider

Specialty Providers may be willing to provide a medical home to selected Members with special needs and conditions. Members that have disabilities, special health care needs, chronic or complex health care needs have the right to request a Specialty Provider as a Primary Care Provider. Members, their legally authorized representative or Primary Care Providers, or the Member's designee may initiate the request. In order to accept such a request, the Specialist Provider must agree to provide all Primary Care services, (i.e. immunizations, well child care/annual check-ups, coordination of all health care services required by the Member).

The Member or their legally authorized representative must also sign the agreement. The Cook Children's Health Plan Medical Director reviews and determines Cook Children's Health Plan approval for a Specialist Provider as a Primary Care Provider. The form to be used for approval of a Specialist to act as a Primary Care Provider is located in the Appendix section of this Provider Manual.

CHIP Perinatal Provider Responsibilities

Role of the CHIP Perinatal Provider

Providers who can provide CHIP Perinatal prenatal care are limited to physicians, community clinics and Providers within the health plan network who offer prenatal care within their scope of practice. This would include Obstetrician/Gynecologists (OB/GYN), Family Practitioners, Nurse Practitioners, Internists and Nurse Midwives.

A CHIP Perinatal Member will select an OB/GYN. A pregnant Member with twelve weeks or less remaining of the pregnancy may stay with her current OB/GYN through postpartum care. The OB/GYN does not have to be an in network Provider to provide services to that Member but the health plan must be notified to coordinate services with the out of network Provider.

CHIP Perinatal Providers will:

- Provide perinatal risk assessment of pregnant and postpartum women and infants up to one year of age
- Provide access to appropriate care based on risk assessment, including emergency care
- Coordinate the transfer and care of a pregnant woman, newborn, or infant to a tertiary care facility when needed
- Provide availability and access of anesthesiologists and neonatologists who can care for complicated perinatal problems
- Provide availability and access of outpatient and inpatient facilities who can deal with complicated perinatal problems

Secure Provider Portal

All Providers should request access to the Secure Provider Portal to verify eligibility, check claim status, and submit prior authorizations and customer service requests.

- Each office must have a Site Administrator
- Visit cookchp.org to register

Network Limitations

Cook Children's Health Plan Member's must seek services from Cook Children's Health Plan network Providers. Providers may refer to any specialist or OB/GYN within the Cook Children's Health Plan network. Providers must ensure that all necessary prior authorizations are obtained prior to providing services. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located

on our website at cookchp.org. Providers should submit prior authorization requests through our Secure Provider Portal.

Verifying Member Eligibility

Prior to providing care to Members, Providers are responsible for verifying a Member's eligibility, identifying which health plan a Member is assigned to, identifying the name of the assigned Primary Care Provider and verifying covered services and whether they require prior authorization.

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

Availability and Accessibility

Appointment Availability

Access to Primary Care, Specialty Care Ancillary, and network Facility Providers, Behavioral Health Providers must be available to Members for routine, urgent, and emergent care as follows:

Waiting times for appointments:

- Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out of area facilities
- Treatment for an urgent condition, including urgent specialty care, must be provided within twenty-four hours
- Routine Primary Care must be provided within fourteen calendar days
- Routine Specialty Care must be provided within twenty-one calendar days
- Initial outpatient behavioral health visits must be provided within ten calendar days
- Initial outpatient behavioral health visits must be provided within seven calendar days upon discharge from an inpatient psychiatric setting
- Primary Care Providers must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than five calendar days
- Prenatal care must be provided within fourteen calendar days, except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five calendar days, or immediately, if an emergency exists
- Preventive health services for adults, including annual adult well check for Members twenty-one years of age and older must be offered within ninety days
- Preventive health services for children, including well-child checkups should be offered to CHIP Members and CHIP Perinatal Newborns in accordance with the American Academy of Pediatrics (AAP) periodicity schedule and to Medicaid Members in accordance with the Texas Health Steps periodicity schedule published

in the Texas Medicaid Provider Procedures Manual

- For a new Member birth through age twenty overdue or upcoming well- child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than fourteen calendar days of enrollment for newborns, and no later than ninety days of enrollment for all other eligible child Members
- The Texas Health Steps annual medical checkup for an existing Member age thirty-six months and older is due on the child's birthday.
- The annual medical checkup is considered timely if it occurs no later than three hundred sixty-four calendar days after the child's birthday.

After Hours Access

Primary Care Providers must be accessible to Members twenty-four hours a day, seven days a week. It is important to keep Cook Children's Health Plan updated with changes to your on-call Providers. The answering service or paging mechanism must provide a response to a Member call within thirty minutes. The following are acceptable and unacceptable telephone arrangements for contacting Primary Care Providers after their normal business hours:

Acceptable after-hours coverage:

- The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups and that can contact the Primary Care Provider or another designated medical practitioner. All calls answered by an answering service must be returned within thirty minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the 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.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the Primary Care Provider or another designated medical Provider, who can return the call within thirty minutes.

Unacceptable after-hours coverage:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells Members to leave a message.
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.

- Returning after-hours calls outside of thirty minutes.

Monitoring Access

Cook Children's Health Plan is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards established by the Health and Human Services Commission. The survey must be conducted each fiscal year and will include verification of Provider directory information and monitor adherence to Provider requirements.

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

- Provider name
- Address
- Phone number
- Office hours
- Days of operation
- Practice limitations
- Languages spoken
- Provider type / Provider specialty
- Length of time a Member must wait between scheduling an appointment and receiving treatment
- Accepting new Members (Primary Care Providers only)
- Texas Health Steps Provider (Primary Care Providers only)

Cook Children's Health Plan will enforce access and other network standards as required by the Health and Human Services Commission and take appropriate action with noncompliant Providers.

Routine, Urgent and Emergency Services

Cook Children's Health Plan follows the Texas Health and Human Services Commission definition of emergency medical condition and emergency behavioral health condition. Based on the following definitions. Cook Children's Health Plan Members may seek care from any Provider in an office, clinic, or emergency room. Treatment for emergency conditions does not require prior authorization or a referral from the Member's Primary Care Provider. Emergency Care staff should contact the Member's Primary Care Physician or Cook Children's Health Plan toll free at 888-243-3312 if a Member presents with a non-emergent condition.

Routine Care

Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. A non-emergent condition is a condition that is neither acute nor severe and can be diagnosed and treated immediately, or that

allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment.

Urgent Condition

Urgent condition means a health condition including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four hours by the Member's Primary Care Provider or Primary Care Provider designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation

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

Emergency Medical Condition

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

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

Emergency Behavioral Health Condition

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

- Requires immediate intervention and/or medical attention without which Member would present an immediate danger to themselves or others
- Which renders a Member incapable of controlling, knowing or understanding the consequences of their actions
- Care for a non-life threatening emergency must be treated within six hours.

Cook Children's Health Plan will pay for professional, facility, and ancillary services provided in a hospital emergency department that are medically necessary to perform the medical screening examination and stabilization of a Member presenting with an emergency medical condition or an emergency behavioral health condition, whether rendered by in network Providers or out of network Providers.

Cook Children's Health Plan will pay for post-stabilization care services obtained within or outside the network that are not pre-approved by a Provider or other health plan representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

- Cook Children's Health Plan does not respond to a request for pre-approval within one hour
- Cook Children's Health Plan cannot be contacted
- Cook Children's Health Plan representative and the treating Provider cannot reach an agreement concerning the Member's care and a network Provider is not available for consultation
    - In this situation, the health plan will give the treating Provider the opportunity to consult with a network Provider and the treating Provider may continue with care of the patient until a network Provider is reached. The health plan's financial responsibility ends as follows:
        - The network Provider with privileges at the treating hospital assumes responsibility for the Member's care
        - The network Provider assumes responsibility for the Member's care through transfer
        - The health plan representative and the treating Provider reach an agreement concerning the Member's care
        - The Member is discharged

Cook Children's Health Plan does not require prior authorization or notification when Member presents with an emergency medical condition or an emergency behavioral condition for emergency room or ambulance services.

Emergency Prescription Supply

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

The seventy-two hour emergency supply should be dispensed any time a prior authorization cannot be resolved within twenty-four 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 prior authorization, the

pharmacy should submit an emergency seventy-two 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 seventy-two hour emergency supply.

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

- "8" in 'Prior Authorization Type Code' (field 461-EU)
- "801" in 'Prior Authorization Number Submitted' (field 462-EV)
- "3" in 'Days Supply' (field 405-D5 in the Claim segment of the billing transaction)
- The quantity submitted in 'Quantity Dispensed' (field 442-E7) should not exceed the quantity necessary for a three 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

Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual and this Provider Manual section for information regarding reimbursement of seventy-two hour emergency supplies of prescription claims. It is important that pharmacies understand the seventy-two hour emergency supply policy procedure to assist Medicaid clients.

Call Navitus toll free 877-907-6023 for more information about the seventy-two hour emergency prescription supply.

Emergency Dental Services

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

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

Non-Emergency Dental Services

Cook Children's Health Plan is **not responsible** for paying for routine dental services provided to Medicaid, CHIP or CHIP Perinate Members. These services are paid through Dental Managed Care Organizations.

Cook Children's Health Plan is **responsible** for paying for treatment and devices for

craniofacial anomalies and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members age six months through thirty-five months.

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

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

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

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

To be reimbursed for durable medical equipment or other products normally found in a pharmacy for children (birth through age twenty), a pharmacy must be enrolled directly with Cook Children's Health Plan on a medical services agreement. Pharmacies that would like to contract directly with Cook Children's Health Plan to dispense covered DME may contact Cook Children's Health Plan Network Development at 888-243-3312. Once contracted, claims for these supplies are submitted to Cook Children's Health Plan. Please refer to the Claims and Billing Section of this Provider Manual for additional information related to claim submission.

Call the Cook Children's Health Plan Member Services Department at 800-964-2247 for information about durable medical equipment and other covered products commonly found in a pharmacy for children (birth through age twenty).

Electronic Visit Verification (EVV)

General Information about EVV?

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

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

Is there a law that requires the use of EVV?

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

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

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

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

- EVV Service Bill Codes Table

Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with a Managed Care Organization (MCO) to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.

- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a Service Provider who delivers a service.

EVV Systems

Do Providers and FMSAs have a choice of EVV Systems?

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

- Data Logic Software Inc.
- First Data Government Solutions

EVV Vendor System

- An EVV Vendor system is an EVV System provided by an EVV Vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV Proprietary System.
- To contact an approved EVV Vendor visit tmhp.com.

EVV Proprietary System

- An EVV Proprietary System is an HHSC approved EVV System that a Provider or FMSA may choose to use instead of an EVV Vendor system.
    - An EVV Proprietary System:
        - Is purchased or developed by a Provider or an FMSA.
        - Is used to exchange EVV information with HHSC or an MCO; and
        - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.
- TMHP Proprietary Systems

Does a CDS Employer have a choice of EVV Systems?

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

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

- To select an EVV Vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System Administrator must complete,

sign, and date the EVV Provider Onboarding Form located on the EVV Vendor's website.
    - TMHP EVV Vendors
- To use an EVV Proprietary System, a Provider or FMSA, signature authority, and the agency's appointed EVV System Administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.
    - TMHP Proprietary Systems

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

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV Vendor.
    - TMHP EVV Vendors
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
    - An EVV Proprietary System Request Form
    - EVV PSO Detailed Questionnaire (DQ)
    - TMHP Interface Access Request
- A program Provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV Proprietary System to comply with HHSC EVV requirements.
- If selecting either an EVV Vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in EVV Training and
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data;
        - Enter or verify Member service authorizations;
        - Setup member schedules (if required); and
        - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

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

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

Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV Vendor to another EVV Vendor within the state vendor pool;
- Transfer from an EVV Vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV Vendor; or
- Transfer from one EVV Proprietary System to another EVV Proprietary System.

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

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

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

Are the EVV Systems accessible for people with disabilities?

The EVV Vendors provide accessible systems, but if a CDS Employer, Service Provider or CDS Employee needs an accommodation to use the EVV System, the vendor will

determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.
If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV Service Authorizations

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

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

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

EVV Clock in and Clock Out Methods

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

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

Mobile Method

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

Home Phone Landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV Vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

Alternative Device

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

- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the Member's home even during an evacuation.

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

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

EVV Visit Maintenance

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

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

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

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

Yes. Program Providers, FMSAs or CDS Employers must select the most appropriate reason code number(s), reason code description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason code number(s) describe the purpose for completing visit maintenance on an EVV visit transaction.
- Reason code description(s) describe the specific reason visit maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for visit maintenance.
- HHSC EVV Reason Codes

EVV Training

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

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

on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

- Cook Children's Health Plan Electronic Visit Verification

Compliance Reviews

What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
    - EVV Usage Review - meet the minimum EVV Usage Score;
    - EVV Required Free Text Review – document EVV required free text; and
    - EVV Landline Phone Verification Review - ensure valid phone type is used.
- Cook Children's Health Plan Electronic Visit Verification

EVV Claims

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

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

Where does a Provider or FMSA submit an EVV claim?

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

For more information on claim submission, please visit Section 5 Claims and Billing of this Provider Manual or review the HHSC Claims Submission Policy.

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

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

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

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

How does the automated EVV claims matching process work?

The claims matching process includes:

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

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

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

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

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

EVV claim match codes viewable in the EVV Portal are:

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

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

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

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

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

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

- TMHP EVV Training webpage

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

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

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

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

Multiple Disabilities (DBMD) program.

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

When should Members call the escalation help line?

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

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

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

Who can call the help line?

Member, Member's authorized representatives or Member's legal representative can call.

Can Members call any time?

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

Ambulance Transportation

Cook Children's Health Plan covers emergency and medically necessary non-emergency ambulance transportation. Network Providers should submit a prior authorization request through our Secure Provider Portal.

Referrals

The Primary Care Provider may arrange for a referral to an in network specialist Provider when a Member requires specialty care services. A specialist may refer to another in network specialist if the Primary Care Provider is notified and concurs with the referral. Primary Care Providers are responsible for coordinating appropriate referrals to other network Providers and specialists, and manage, monitor and document the services of other Providers. Referral documentation must be included in the Member medical record.

Referrals from a network Primary Care Provider to a network Specialist (for evaluation

only), network facility, or contractor do NOT require prior authorization. Some treatment(s) may require a prior authorization when performed by an in network Provider. Providers should ensure authorization is not required prior to performing treatment(s).

All out of network referrals MUST receive prior authorization from Cook Children's Health Plan before the out of network referral can occur. Out of network referrals may be permitted when services are unavailable from a Cook Children's Health Plan in network Provider, facility, or contractor.

The Provider is responsible for initiating the prior authorization process when a Member requires medical services or inpatient admission.

Members may access the following services without a Primary Care Provider referral:

- Network Ophthalmologist or Therapeutic Optometrist to provide Eye Health Care services other than surgery
- Emergency Services
- OB/GYN Care
- Behavioral Health Services

Vision Services

Cook Children's Health Plan has contracted with a Vision Provider for routine vision screenings. A vision screening is an examination by an Optometrist or other Provider to determine the need for and to prescribe corrective lenses and frames. The Providers for these services are listed in the Provider directory or Members may call the Vision Provider indicated on the Member's ID card.

Member's may select and have access to, without a Primary Care Provider referral, a network Ophthalmologist or Therapeutic Optometrist to provide eye health care services, other than surgery. For a medical diagnosis, the Member should contact their Primary Care Provider to be referred to an Ophthalmologist.

Behavioral Health Referrals

We all recognize that the prevalence of psychosocial complaints and chemical dependency disorders are high. Providers should make every effort to elicit and diagnose these problems. Cook Children's Health Plan considers it to be part of the Provider's scope of care to provide basic screening and evaluation procedures for detection and treatment of, or referral for, any known suspected behavioral health problems and disorders from attention deficit disorder, to chemical dependency, depression, and anxiety states.

Should you encounter any Member who appears to be in need of mental health or chemical dependency services, please direct that Member to contact Member Services at 800-964-

2247 for assistance in locating a network Behavioral Health Provider. In such instances, a referral is not required.

Additional information on behavioral health services is located in the Behavioral Health Services section of this Provider Manual.

Member's Right to Designate an OB/GYN

Cook 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. The Member has the right to designate their OB/GYN as their Primary Care Provider.

Attention to Female Members

Members have the right to pick an OB/GYN without a referral from your 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

Access to Second Opinion

Cook Children's Health Plan ensures that each Member has the right to a second opinion regarding the use of any medically necessary covered service. Either a Member or an in network Provider may request a second opinion. The second opinion must be obtained from a network Provider when available. If a network Provider is not available, the Member may obtain the second opinion from an out of network Provider at no additional cost to the Member. All out of network requests require prior authorization from Cook Children's Health Plan. The health plan may also request a second opinion. The reasons include, but are not limited to:

- A Member or Provider voices a concern about care
- When an experimental or investigational service is requested
- Possible outcomes or risks of requested treatment are identified by Cook Children's Health Plan

When Cook Children's Health Plan requests a second opinion, the health plan will arrange the appointment and notify the Member and the Primary Care Provider of the date and time of the appointment. Cook Children's Health Plan will request that the consulting Provider send his/her opinion to the Primary Care Provider and the health plan.

Advance Directives

Federal and state law require Providers to maintain written policies and procedures for informing and providing written information to all adult Members eighteen (18) years of age and older about their rights to refuse, withhold, or withdraw medical treatment and mental health treatment through advance directives (Social Security Act §1902[a][57] and §1903[m][1][A]). The Provider's written policies and procedures must comply with provisions contained in 42 CFR §489, Subpart I, relating to the following state laws and rules:

- A Member's right to self-determination in making healthcare decisions
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    - A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition
    - A Member's right to make written and non-written Out-of-Hospital do-not-resuscitate (DNR) Orders
    - A Member's right to execute a Medical Power of Attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent
    - Chapter 137, The Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment

Providers must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

Cook Children's Health Plan Members who have questions or would like additional information about Advance Directive can call Cook Children's Health Plan Member Services at 800-964-2247.

Texas Vaccines for Children Program

Since 1994, Texas has participated in the Federal Vaccines for Children Program (VFC). Our version is called the Texas Vaccines for Children Program (TVFC). The Program was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to Providers, in order to immunize children (birth through eighteen years of age) who meet the eligibility requirements.

Qualified Medicaid and CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC webpage dshs.state.tx.us.

Coordination with Texas Department of Family and Protective Services

Cook Children's Health Plan works with Texas Department of Family and Protective Services to ensure that the at-risk population, both children in custody and not in custody of Texas Department of Family and Protective Services, receive the services they need. Children who are served by Texas Department of Family and Protective Services may transition into and out of Cook Children's Health Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area. Providers must coordinate with Texas Department of Family and Protective Services and foster parents for the care of a child who is receiving services from or has been placed in conservatorship of Department of Family and Protective Services. Providers must respond to requests from Department of Family and Protective Services, including:

- Provide medical records to Texas Department of Family and Protective Services
- Testifying in hearings; and
- Refer suspected cases of abuse and neglect to Department of Family and Protective Services
- Schedule medical and behavioral health services appointments within fourteen days unless requested earlier by Department of Family and Protective Services

A Member in the custody of Texas Department of Family and Protective Services may continue to receive services until he or she is disenrolled from Cook Children's Health Plan due to loss of Medicaid Managed Care eligibility or placement in foster care.

Notification of Updates in Provider Information

Network Providers must inform both Cook Children's Health Plan and the Health and Human Services administrative services contractor of any changes to the Provider's contact information including address, telephone and fax number, group affiliation, etc. Cook Children's Health Plan also requests Providers inform us of any updates to panel status such as an update from a closed panel to an open panel as well as any changes to age restrictions. Providers must also ensure that the health plan has current billing information on file to facilitate accurate payment delivery.

Providers may submit demographic changes via the Secure Provider Portal.

Providers must also communicate changes to TMHP. The Provider Enrollment and Management System (PEMS) step by step guide provides guidance on submitting demographic updates to TMHP. Providers can locate more information about the Provider Enrollment and Management System on tmhp.com.

Credentialing and Recredentialing

Cook Children's Health Plan's credentialing process is designed to meet the National Committee for Quality Assurance (NCQA) and state requirements for the evaluation of Providers who apply for participation. Providers must submit all required information in order to complete the credentialing or recredentialing process. Incomplete applications cannot be processed until all requested documentation is received.

New Providers must complete a Letter of Interest Form along with all of the required documents. The Letter of Interest form is located on our website at cookchp.org, select Providers, and then select Joining the Network. Send the completed packet to Network Development by email CCHPNetworkDevelopment@cookchildrens.org or fax 682-885-8403.

Upon receipt of a completed application and any requested documentation, the credentialing process for a new Provider will be completed within ninety days. The recredentialing process will occur at least every three years. In addition to verifying credentials, the health plan will consider Provider performance data including Member complaints and appeals, quality of care and utilization management.

Practitioner Rights

When the credentialing process is initiated for practitioners and organizations, the applicant is entitled to:

- Review information submitted to support their credentialing application
- Correct erroneous information
- Receive the status of their credentialing or recredentialing application, upon request

Providers may contact the Network Development team for credentialing, contracting, and corrections of erroneous information by phone 888-243-3312, fax 682-885-8403 or email CCHPNetworkDevelopment@cookchildrens.org.

Provider Contracts

Cook Children's Health Plan believes effective quality improvement requires Provider/ Practitioner involvement to the fullest extent possible in quality initiatives. Contracts specifically require Providers/Practitioner to:

- Cooperate with Quality Improvement activities
- Provide Cook Children's Health Plan with access to member medical records to the extent permitted by state and federal law
- Allow Cook Children's Health Plan to use their performance data for quality improvement activities
- Maintain the confidentiality of Member information and records

Termination

Provider Requests Termination

If a Provider chooses to leave the network, a ninety day written notice is required. Refer to Advance Notice to Members' in the Term and Termination section of the Service Agreement.
Provider's choosing to leave Cook Children's Health Plan are required to:

- Notify their health plan Members of their upcoming termination date
- Notify the health plan in their termination request if Members should be reassigned to another Provider in the office

Please send the written notice to:

- Fax: 682-885-8403
- Email: CCHPNetworkDevelopment@cookchildrens.org
- Or mail:

Cook Children's Health Plan
Attention: Network Development
PO Box 2488
Fort Worth, TX 76113-2488

Termination of Provider by Cook Children's Health Plan

Cook Children's Health Plan may terminate a Provider's participation in the health plan in accordance with its participation contract with the Provider and any applicable appeal procedures. Cook Children's Health Plan will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider. At least ninety days before the effective date of the proposed termination of the Provider's contract, Cook Children's Health Plan must provide a written explanation to the Provider of the reasons for the termination. The health plan may immediately terminate a Provider contract in a case involving:

1. Imminent harm to patient health.
2. An action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession.
3. Fraud or malfeasance.

Not later than thirty days following receipt of the termination notice, a Provider may request a review of Cook Children's Health Plan's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and Providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty,

if available, appointed to serve on the standing quality assurance committee or utilization review committee of Cook Children's Health Plan. The decision of the advisory review panel must be considered by Cook Children's Health Plan but is not binding on the health plan. Within sixty days following the Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Cook Children's Health Plan must communicate its decision to the Provider. Cook Children's Health Plan must provide to the affected Provider, on request, a copy of the recommendations of the advisory review panel and the health plan's determination.

A Provider's participation in Cook Children's Health Plan shall be automatically terminated for any of the following:

- Loss, suspension, or probation of professional licensure, certification, or registration.
- Loss of either state or federal or both controlled substances registration.
- Loss of required professional liability insurance coverage.
- Exclusion from the Medicare, Medicaid, or any other federal health care program.
- Failure to meet the board certification requirement unless granted an exception as set forth in the criteria.

Fraud Information

Reporting Waste, Abuse or Fraud by a Provider or a Client Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse, or Fraud?

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

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

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

- Call the OIG Hotline at 800-436-6184
- Visit https://oig.HHS.state.tx.us/

- Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or

- You can report directly to your health plan:

Cook Children’s Health Plan
P.O. Box 2488
Fort Worth, TX 76113-2488
888-243-3312

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

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

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

When reporting about someone who gets benefits, include:

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

Provider’s Annual Medicaid Payments

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, 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.

Abuse, Neglect or Exploitation

This section addresses the identification and reporting of abuse, neglect and exploitation.

Abuse

The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical, sexual, emotional harm or pain to a person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

Neglect

The failure to provide for the goods or services, including food, clothing, shelter and/or medical services, which are necessary to avoid physical, emotional harm or pain. This includes leaving someone who cannot care for him or herself in a situation where he or she is at risk of harm due to situations such as starvation, dehydration, over or under medication, unsanitary living conditions, lack of heat, running water, electricity or personal hygiene.

Exploitation

The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with a person that involves using, or attempting to use, the resources of the person, including the person's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the person.

Reporting Abuse, Neglect or Exploitation

Medicaid Managed Care

Report suspected Abuse, Neglect, and Exploitation:

Cook Children's Health Plan and Providers must report any allegation or suspicion of Abuse Neglect Exploitation that occurs within the delivery of long term services and supports to the appropriate entity. The managed care contracts include Cook Children's Health Plan and Provider responsibilities related to identification and reporting of ANE. Additional state laws related to Cook Children's Health Plan and Provider requirements

continue to apply.

The Provider must provide Cook Children's Health Plan with a copy of the Abuse, Neglect and Exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the Provider is responsible for reporting individual remediation on confirmed allegations to Cook Children's Health Plan.

Report to the Health and Human Services Commission

If the victim is an adult or child who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHSC
- Adult day care centers
- Licensed adult foster care Providers

Contact HHSC at 800-458-9858.

Report to the Department of Family and Protective Services

If the victim is one of the following:

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

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

Report to Local Law Enforcement

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

Failure to Report or False Reporting

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

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

Educating Members about Managed Care

Providers cannot enroll Medicaid clients; however, Providers are encouraged to educate Members about Medicaid Managed Care. Providers that participate in one or more Texas Medicaid Managed Care plans should follow these rules when educating clients:

- Providers may not influence clients to choose one MCO or dental plan over another.
- Providers must inform clients of all Medicaid managed care health plans and dental plans in which the Provider participate.
- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- Providers may inform clients of special services offered by all Medicaid managed care health and dental plans in which the Providers participate.
- Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the Providers participate.
- Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.
- Providers may not influence clients based on reimbursement rates or methodology

used by a particular plan.

- At the Member's request, Providers can provide the necessary information for the client to contact a particular plan but cannot promote any plan over another.
- In no instances can Providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined on the previous page, and clients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the client, not by the Provider or the Provider's agent.
- Providers may assist clients with completing the Medicaid application.
- Providers may display stickers that indicate that they participate in a particular Medicaid managed care health or dental plan as long as they do not indicate anything more than "(health plan or dental plan) is accepted or welcomed here" (provided the sticker meets Medicaid/CHIP Marketing Guidelines regarding size limitations).
- Providers may display state-approved, health related marketing materials in their offices, provided it is done equally for all MCOs and dental plans in which they participate. MCO and dental plan Providers cannot give out or display plan-specific marketing items or giveaways to clients.

Laws, Rules and Regulations

The network Provider understands and agrees that the following laws, rules and regulations, and all amendments or modifications apply to the network Provider contract:

1. Environmental protection laws:
    a. Pro-Children Act of 1994 (20 U.S.C.§6081 *et seq.* regarding the provisions of a smoke-free workplace and promoting the non-use of all tobacco products;
    b. National Environmental Policy Act of 1969 (42 U.S.C.§4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
    c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with respect to Federal Contracts, Grants and Loans");
    d. State Clean Air Implementation Plan (42 U.C.S. § 740 *et seq)* regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
    e. Safe Drinking Water Act of 1974 (21 U.S.C. § 349; 42 U.S.C. §300f to 300j-9) Relating to the protection of underground sources of drinking water;
2. State and Federal anti-discrimination laws:
    a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d *et seq.)* and as applicable 45 C.F.R. Part 80n or 7 C.F.R. Part 15;
    b. Section 504 of the Rehabilitation Act of 1973 (29U.S.C. §794);

c. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.)*;
d. Age Discrimination Act of 1975 (42 U.S.C. §6101-6107);
e. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
f. Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq.)*;
g. Executive Order 13279, and it's implementing regulations of 45 C.F.R. Part 87 or 7 C.F.R. Part 16 and;
h. The HHSC agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

3. The Immigration and Nationality Act (8 U.S.C. §1101 *et seq.)* and all subsequent immigration laws and amendments;
4. The Health Insurance Portability Act of 1996 (HIPPA) (Public Law 104-191, and
5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et. Seq*.

Program Violations

Program violations arising out of performance of the contracts are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

Required Medical Record Documentation

The following is a list of standards that medical records must reflect all aspects of patient care, including ancillary services:

- Each page or electronic file in the record contains the Member's name and ID number
- Age, sex, address and phone number are recorded
- All entries are dated (month, day and year) and the author identified
- All entries are legible to individuals other than the author
- Allergies and adverse reactions (including immunization reactions) are prominently noted in the record
- Past medical history is recorded for all Members seen three or more times
- Immunizations are noted in the record as complete or up to date
- Medication information is recorded in a consistent and readily accessible location
- Current problems and active diagnoses are recorded in a consistent and readily accessible location
- Member education regarding physical and/or behavioral health problems is documented
- Notation concerning tobacco, alcohol and substance abuse and documentation of relevant Member education is present on an age appropriate basis
- Consultations, referrals and specialist reports are included

- Emergency care is documented
- Hospital discharge summaries are included
- Evidence and results of screening for medical, preventive and behavioral health screening are present
- Diagnostic information is appropriately recorded
- Treatment provided and results of treatment are recorded
- Documentation of the team members involved in the care of Members requiring a multidisciplinary team
- Documentation in both the physical and behavioral health records showing appropriate integration of care
- Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination
    - Appropriate subjective and objective information is obtained for the presenting complaints
- For Members receiving behavioral health treatment, documentation to include "at risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social history)
- Admission or initial assessment includes current support systems or lack of support systems
- For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period
- Plan of treatment that includes activities/therapies and goals to be carried out
- Diagnostic tests
- Therapies and other prescribed regimens. For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate
- Follow-up Encounter forms or notes have a notation, when indicated, concerning follow up care, call or visit. Specific time to return is noted in weeks, months, or PRN
- Unresolved problems from previous visits are addressed in subsequent visits
- Referrals and results thereof
- Consultation, lab and imaging reports noted to indicate review and follow up plans by Primary Care Provider
- All other aspects of Member care, including ancillary services
- For Members eighteen years of age and older, documentation of advance directives and/or mental health declaration, or indication of education

Providers are required to maintain medical records, including electronic medical records that conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other State and Federal laws. Medical records should be kept in a secure location and accessible only by authorized personnel.

Access to Records

Receipt of Record Review Request

Provider must provide at no cost to HHSC:

1. All information required under Cook Children's Health Plan's managed care contract with HHSC, including but not limited to, the reporting requirements and other information related to the Provider's performance of its obligation under the contract.
2. Any information in its possession sufficient to permit Health and Human Services Commission to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

Upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, a Provider must provide, at no cost to the requesting agency, the records requested within three business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than twenty-four hours, the Provider must provide the records requested at the time of the request or in less than twenty-four hours.

The request for record review includes clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other Health and Human Services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting, billing records, invoices, documentation of delivery items, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with Providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the Provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.

Audit or Investigation

Providers must provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Provider contract and any records, books, documents, and papers that are related to the Provider contract and/or the Provider's performance of its responsibilities under the contract:

1. United States Department of Health and Human Services or its designee.
2. Comptroller General of the United States or its designee.
3. Managed Care Organization Program personnel from HHSC or its designee.
4. Office of Inspector General.
5. Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee.
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC.
7. Office of the State Auditor of Texas or its designee.
8. State or Federal law enforcement agency.
9. A special or general investigating committee of the Texas Legislature or its designee.
10. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

Providers must provide access wherever it maintains such records, books, documents, and papers. The Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following requests:

1. Examination
2. Audit
3. Investigation
4. Contract administration
5. The making of copies, excerpts, or transcripts
6. Any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions

The Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

Cultural Competency

Reading/Grade Level Consideration

Because of the cultural diversity of the Cook Children's Health Plan Member population, not all members have comprehensive reading levels. Therefore, in order to facilitate understanding all Cook Children's Health Plan materials, such as the Member Handbook, website and correspondence, are written at or below a sixth grade Flesch-Kincaid level in both English and Spanish. This will be accomplished by testing all text with the Microsoft Word's readability tool. Other languages will be provided when the language required is

spoken by ten percent or more of the enrolled population. Additionally, Cook Children's Health Plan will provide written translation in languages other than English and Spanish when requested.

Sensitivity and Awareness

Cultural and linguistic competency is defined as a set of linguistic, human interaction, and ethnic, cultural, and physical and mental disability awareness skills that permit effective communication and interaction among human beings. The term culture, in this definition, also includes the beliefs, rituals, values, institutions and customs associated with racial, ethnic, religious or social groups and individuals of all nationalities. Understanding and maintaining sensitivity to all of the factors that impact human behavior, attitudes and communications is integral to assuring the provision of quality, compassionate and effective health care services to the Members of Cook Children's Health Plan.

Cultural (or multicultural) competency is addressed in this plan from two perspectives:

- Human interaction and sensitivity
- Culturally effective health care services to Cook Children's Health Plan Members by network Providers

Physicians and other health care practitioners are compelled to understand the customs, rituals, and family values of the various cultural groups (in addition to assuring effective linguistic translations/communications) of their patients in order to provide quality and effective health care.

Within the service area of Cook Children's Health Plan, many diverse cultural groups are represented. It is the beliefs, customs, languages, rituals, values and other aspects of the North Texas regional population which must be understood and addressed by Cook Children's Health Plan staff and affiliated Providers in order to provide quality service and quality, effective health care. Cook Children's Health Plan will, as part of this Plan, conduct an education and training program on cultural competency described below:

Employee Training

Cook Children's Health Plan hires a diverse group of employees in all levels of our organization. Cook Children's Health Plan does not discriminate with regard to race, religion or ethnic background when hiring staff. All new employees will be trained on this Plan during Cook Children's Health Plan's new employee orientation. All employees will have access to the Plan as a guide for providing culturally competent services to our Members.

Provider Training

Cook Children's Health Plan contracts with a diverse Provider network. Cook Children's Health Plan's Providers speak a wide array of languages including Spanish, Vietnamese, Chinese and Hindi. Cook Children's Health Plan's Provider Directory includes the languages spoken in the Provider offices to assist our Members with selecting a Provider that would meet their medical needs as well as having the ability to directly speak to the Provider in their language. All Providers that are new to the health plan receive an initial orientation which includes information about this Plan. All Providers also receive education and training on an ongoing basis.

Providers should educate themselves about the health care issues common to different cultures and ethnicities. When an encounter with a Member is difficult due to cultural barriers, they should prepare for future visits by researching and asking for the Member's input.

Newsletters

Cook Children's Health Plan develops Member Newsletters and Provider Newsletters on a quarterly basis. These newsletters are used to communicate to our Members and Providers about any new information of interest. It is also used as a tool to remind our Members and Providers about various aspects of the health plan.

Member Handbook

Cook Children's Health Plan's Member Handbook is sent to every new Member that joins our health plan. The Member Handbook includes information about our Cultural Competency and Translation Services Plan. Information included in the handbook consists of an explanation of the translation services available to our Members, the ability to speak to a Spanish speaking Member Services Representative, the ability to communicate with our Health Plan using the TDD/TTY phone as well as information requesting the Member materials in ways to assist Members with other disabilities such as materials for the visually impaired.

Language Translation Services

Cook Children's Health Plan provides several options for the non-English speaking or hearing impaired Members (or their parents) to communicate with the health plan. Cook Children's Health Plan will coordinate language translation services with the Provider as needed. These options are described in the sections below.

In House Translation Services

Cook Children's Health Plan employs bilingual staff members in the Member Services, Claims, and Care Management departments. Bilingual staff is available for Spanish

translation services Monday through Friday from 8:00 a.m. - 5:00 p.m. by calling toll free 800-964-2247.

Cyra Communications

Cook Children's Health Plan subscribes to CyraCom International (CyraCom), a translation service offering competent translations of most commonly spoken languages around the world. This service is available to our Members 8:00 a.m. - 5:00 p.m., Monday through Friday, excluding holidays. Cook Children's Health Plan staff is trained in how to access this line in order to communicate with Members from essentially all local ethnic groups. CyraCom interpreters have received special training in terminology and standard business practices in the HMO and healthcare industries.

All CyraCom operators are trained in the following key areas:

- Facilitate emergency room and critical care situations
- Accelerate triage and medical advice
- Simplify the admitting process
- Improve billing and collection processes
- Process insurance claims
- Process prescriptions
- Provide outpatient and in-home care
- Change Primary Care Providers
- Communicate with non-English speaking family Members

Cook Children's Health Plan Members can access the CyraCom translation services by calling the main number to Cook Children's Health Plan at 800-964-2247. Cook Children's Health Plan employees will conference in a CyraCom translator who can facilitate the communication. Network Providers who encounter a Cook Children's Health Plan Member who cannot speak English may also contact the Health Plan for translation services. Either an in-house Cook Children's Health Plan translator will be provided via telephone or a CyraCom translator will be conferenced in to assure that effective communication occurs. Providers are made aware of services available through information included in the Provider Manual and periodic Provider Newsletters.

Multi-lingual Written Member Materials

All published Member materials will be available in both English and Spanish. Whenever a particular segment of the Cook Children's Health Plan population reaches ten percent or more of the total population, materials will be translated into the predominant language of that population.

Multi-lingual Web Site

Cook Children's Health Plan has established and maintains a web site for Cook Children's Health Plan Members in both English and Spanish. Cook Children's Health Plan's website is constructed such that Members with access devices that have industry-standard technological capabilities can easily access and surf the web site. The web site will be translated into additional languages as that specific segment of the population reaches ten percent or more of the total population. The Cook Children's Health Plan website is located at cookchp.org.

Multi-lingual Recorded Messages

Cook Children's Health Plan will record all voice messages on its main business lines and Member Services Hotline/Call Center in both English and Spanish. When a particular segment of the Cook Children's Health Plan population reaches ten percent or more of the total population, recorded messages will be added to main business lines and Member Services Hotline/Call Center in the predominant language of that additional population (or populations).

Provider Directory Language Information

The Provider Directory published by Cook Children's Health Plan will be in both English and Spanish (and other languages when needed as described above) and will identify Providers who are proficient in various languages. This information will help Cook Children's Health Plan Members select Providers who are culturally compatible with their family and who can communicate effectively with the Member(s).

Services for Hearing, Visual, & Access Impaired

Cook Children's Health Plan has many years of experience within the organization in communicating with children and family Members who are either visually or hearing impaired or both. In addition, Cook Children's Health Plan accesses all Cook Children's Health Care System resources available on an as needed basis to assure effective communications with its hearing and visually impaired Members and their families.

Services for the Hearing Impaired

Cook Children's Health Plan has a service agreement with Texas Interpreting Services (TIS). TIS employ staff members who are proficient in sign language communications for hearing impaired individuals. These services are available to Cook Children's Health Plan staff and Providers on an as needed basis. If a Provider is in need of a sign language interpreter, they can contact Cook Children's Health Plan in advance of the scheduled appointment and the health plan will coordinate services with TIS.

Telecommunications Devices for the Deaf (TDD)

Cook Children's Health Plan employs telecommunications devices that can effectively

communicate with hearing impaired Members. Whenever a “silent call” is received on the Cook Children’s Health Plan Member and/or Provider Support Services line, staff will handle such calls by utilizing telephonic communications devices that permit the representative to communicate with the Member/caller using the TDD/TTY.

Internet Member Services Access

Members who are hearing impaired may communicate via email over the internet, whenever the Member has access to such services, for all of their business relative to STAR.

Services for the Visually Impaired

Cook Children’s Health Plan also provides alternative communication services for Members/families who are visually impaired. These services include:

- Verbal communications and assistance via phone or in person to assist the Member with:
    - Understanding plan benefits
    - Selecting an appropriate Primary Care Provider
    - Resolving billing or other questions
    - Other concerns or questions regarding their plan or plan benefits
- Audiotape versions of the Member Handbook and other Member communications regarding the plan or plan benefits and limitations are available upon request

Access to Services for Members with Physical and Modality Limitations

As part of the inventory of items that Cook Children’s Health Plan Provider Relations staff checks when performing on site office visits to network Provider offices/locations, information is gathered to determine if the facilities provide access for Members with physical and mobility limitations.

Providers are required to meet the minimum standards for access prescribed by the Americans with Disabilities Act (ADA) and terms and conditions outlined in the Cook Children’s Health Plan Provider Services Agreement.

Telemedicine, Telehealth, and Telemonitoring Access

Telemedicine, Telehealth, and Telemonitoring are covered services and are benefits of Texas Medicaid as provided in the Texas Medicaid Provider Procedures Manual. Prior authorization is not required for these services. Cook Children’s Health Plan encourages network participation with Providers offering these services to provide better access to healthcare for our Members. The health plan will accept and process Provider claims for these services in conformity with the Texas Medicaid benefit.

Provider Coordination

Cook Children's Health Plan will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. Specialty Providers may function as a Primary Care Provider for treatment of Members with chronic/complex conditions when approved by the health plan.

Children's Health Plan will ensure the Members with special health care needs have adequate access to Primary Care Providers and Specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist Members with special health care needs, their families and health care Providers to facilitate access to care, continuity and coordination of services.

Section 2: Member Eligibility and Enrollment

Medicaid (STAR) Member Enrollment and Eligibility Enrollment

HHSC in coordination with the State Enrollment Broker administer the enrollment process for Medicaid eligible individuals. Eligible individuals must reside in one of the counties in the Tarrant Service Area. Medicaid clients who are eligible for STAR choose a Managed Care Plan and a Primary Care Provider using the official state enrollment form or by calling the Enrollment Broker. The date that a Medicaid Member becomes eligible for Medicaid and the effective date of enrollment with the Managed Care Plan are not the same. HHSC will make the final determination regarding Medicaid eligibility.

The Help Line (Enrollment Broker) is available 8:00 a.m. - 8:00 p.m. Central Time, Monday through Friday at:

- Telephone: 800-964-2777
- Telecommunications device for the deaf: 800-267-5008

Automatic Re-enrollment

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

Disenrollment

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

Disenrollment from Cook Children's Health Plan

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

- Member misuses or loans their managed care identification card to another person to obtain services
- Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the Managed Care Plan seriously impairs the Managed Care Plan's or Provider's ability to provide services to either the Member or other Members, and Member's behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow the Managed Care Plan to treat the underlying medical condition or using a Provider that is not in network)

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

Member Removal from a Provider Panel

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

- The Member gives their Cook Children's Health Plan identification card to another person for the purpose of obtaining services
- The Member continually disregards the advice of their Primary Care Provider
- The Member repeatedly uses the emergency room in an inappropriate fashion

The request to remove a Member from a Provider panel must be in writing and sent to Cook Children's Health Plan Member Services Department. Providers may contact Cook Children's Health Plan at 888-243-3312 with questions regarding this process.

Pregnant Women and Infants

The Medicaid Enrollment Broker processes applications for pregnant women within fifteen days of receipt. Once an applicant is certified as eligible, a Medicaid ID number will be issued to verify eligibility and to facilitate Provider reimbursement. Pregnant women, including pregnant teens, may be retroactively enrolled in the STAR program based on

their date of eligibility.

Newborns are covered under their mother's health plan for at least ninety days following the date of birth, unless the mother requests a change. The mother can ask for a health plan change before the ninety days by calling the Enrollment Broker. The Member cannot change from one health plan to another plan during an inpatient hospital stay.

Mothers are encouraged to contact the Enrollment Broker to enroll the newborn in the STAR program. Mothers are also encouraged to select a Primary Care Provider for the newborn prior to birth. Primary Care Provider selections can be done by calling Cook Children's Health Plan Member Services at 800-964-2247.

Pregnant Teens

Providers are required to contact Cook Children's Health Plan immediately when a pregnant STAR teen is identified.

Newborn Process

In the STAR Program, newborns are automatically assigned to the managed care plan the mother is enrolled with at the time of the newborn's birth for a period of at least ninety days. The mother can ask for a health plan change before the ninety days by calling the Enrollment Broker. The Member cannot change from one health plan to another plan during an inpatient hospital stay.

Health Plan Changes

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

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

Members can change health plans by calling the Texas Medicaid Managed Care Program

Helpline at 800-964-2777. However, a Member **cannot** change from one health plan to another health plan during an inpatient hospital stay.

Medicaid (STAR) Member Eligibility

HHSC will make the final determination regarding Medicaid eligibility. Medicaid Members who are eligible for STAR choose a Managed Care Plan and a Primary Care Provider using the official state enrollment form or by calling the Enrollment Broker.

The Provider is responsible for requesting and verifying the Member's current eligibility before providing services. The Provider must also verify and abide by prior authorization or administrative requirements established by the managed care plan. The Medicaid Member's managed care plan information can be verified by:

- Calling the Your Texas Benefits help line at 855-827-3747
- Checking the Member's health plan ID card
- Calling the Member's health plan

The Member's managed care eligibility can also be verified using:

- TMHP's Automated Inquiry System (AIS) at 800-925-9126
- National Council for Prescription Drug Programs (NCPDP) E1 transaction
    - The E1 transaction is submitted through the pharmacy's point-of-sale system

Verifying Member Medicaid Eligibility

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

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

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

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

Members can log in to YourTexasBenefits.com to see their benefit and case information, print or order a Medicaid ID card, set up Texas Health Steps alerts, and more. If you have

questions, call 855-827-3747 or email ytb-card-support@hpe.com.

Temporary Medicaid Identification

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

TexMedConnect

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

Automated Inquiry System (AIS)

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

Eligibility and claim status information is available on AIS twenty-three hours a day, seven days a week, with scheduled down time between 3:00 a.m. - 4:00 a.m. Central Time. All other AIS information is available from 6:00 a.m. - 6:00 p.m., Central Time, Monday through Friday. TMHP call center representatives are available 7:00 a.m. - 7:00 p.m., Central Time, Monday through Friday. AIS offers fifteen transactions per call.

Verifying Health Plan Eligibility

Providers are responsible for verifying a Member's eligibility, identifying which health plan a Member is assigned to, identifying the name of the assigned Primary Care Provider and verifying covered services and if they require prior authorization for each visit prior to providing care to Members. There are several ways this can be done:

- Member identification cards
- Telephone verification
    - Member Services (local): 682-885-2247
    - Member Services (toll-free): 800-964-2247
- Membership listings

- Cook Children's Health Plan Secure Provider Portal
    - cookchp.org

Cook Children's Health Plan recommends that Providers verify eligibility through all available means prior to providing care to Members.

Pharmacy Providers can verify eligibility electronically through NCPDP E1 Transaction, National Council for Prescription Drug Programs (NCPDP) E1 transaction. The E1 transaction is submitted through the pharmacy's point-of-sale system.

Cook Children's Health Plan Identification Card

The Cook Children's Health Plan STAR Member identification card identifies the health plan and Primary Care Provider that has been selected by the Member. If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. The card includes the following essential information:

- Member Name
- Member Identification Number
- Health Plan Telephone Number
- Primary Care Provider's name and telephone number

While the health plan identification card does identify the Member, it does not confirm eligibility. This is because Member eligibility can change on a monthly basis without notice. Provider should use all available resources to confirm current Member eligibility prior to rendering services. Primary Care Providers should not treat any Member whose identification materials identify a different Primary Care Provider or health plan.

An example of a STAR Program Member ID Card is located in the Appendix section of this Provider Manual.

Dual Eligible Members

Dual eligible Members have both Medicare and Medicaid health insurance coverage. Medicare or the Member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare covered services. The state Medicaid program services as a secondary payer and will Provider all medically necessary covered services that are not covered by Medicare to dual eligible Members.

Member Listing for Primary Care Provider

Each Primary Care Provider receives a monthly listing of Members who selected that Provider as their Primary Care Provider. The membership listing is available on our Secure Provider Portal at cookchp.org.

Member's Right to Designate an OB/GYN

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

STAR Member Rights and Responsibilities Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    - Be treated fairly and with respect.
    - 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:
        - Be told how to choose and change your health plan and your Primary Care Provider.
        - Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
        - Change your Primary Care Provider.
        - Change your health plan without penalty.
        - 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:

- 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.
- 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:
    - Work as part of a team with your Provider in deciding what health care is best for you.
    - Say yes or no to the care recommended by your Provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews (EMR) and State Fair Hearings. That includes the right to:
    - Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.
    - Get a timely answer to your complaint.
    - Use the plan's appeal process and be told how to use it.
    - Ask for an external medical review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    - Ask for a State Fair Hearing without an external medical review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    - Get medical care in a timely manner.
    - 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.
    - 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.
    - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

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

Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    - Learn and understand your rights under the Medicaid program.
    - Ask questions if you do not understand your rights.
    - 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:
    - Learn and follow your Health Plan's rules and Medicaid rules.
    - Choose your Health Plan and a Primary Care Provider quickly.
    - Make any changes in your Health Plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
    - Keep your scheduled appointments.
    - Cancel appointments in advance when you cannot keep them.
    - Always contact your Primary Care Provider first for your non-emergency medical needs.
    - Be sure you have approval from your Primary Care Provider before going to a specialist.
    - 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:
    - Tell your Primary Care Provider about your health.
    - Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    - 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:
    - Help your Providers get your medical records.
    - Work as a team with your Provider in deciding what health care is best for you.
    - Understand how the things you do can affect your health.
    - Do the best you can to stay healthy.
    - Treat Providers and staff with respect.
    - Talk to your Provider about all of your medications.

Additional Member Responsibilities while using Access2Care

When requesting Non-Emergency Medical Transportation (NEMT) Services, you must provide the information requested by the person arranging or verifying your transportation. You must follow all rules and regulations affecting your NEMT services.

1. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
2. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
3. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.

You must only use NEMT services to travel to and from your medical appointments. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

CHIP and CHIP Perinate Newborn Member Enrollment and Eligibility Enrollment

The Health and Human Services Commission determines CHIP eligibility and will enroll and disenroll eligible individuals into and out of the CHIP program.

To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident
- A Texas resident
- Under age nineteen
- Uninsured for at least ninety days
- Living in a family whose income is at or below two hundred one percent Federal Poverty Level (FPL)

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

A CHIP Member is enrolled for a period of twelve months from the date the Member is first covered by the Plan. Enrollment in the CHIP program will begin on the first day of the month after eligibility is determined. Retroactive enrollment in the CHIP program would be

determined by HHSC.

Reenrollment

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

Disenrollment

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

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

Providers may not take retaliatory action against a CHIP Member due to disenrollment. If a CHIP program Member's effective date of coverage occurs while the Member is confined in a hospital, the MCO is responsible for the Member's costs of covered services beginning on the effective date of coverage. If a Member is disenrolled while the Member is confined in a hospital, the MCO's responsibility for the Member's costs of covered services terminates on the date of disenrollment.

Health Plan Changes

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

- For any reason within ninety 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.

CHIP Member Eligibility

- Twelve month eligibility for CHIP program Members.
- A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for twelve months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker:
    - A CHIP Perinate mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through emergency Medicaid. Clients under Medicaid eligibility threshold will receive a form H3038 with their enrollment confirmation.
    - Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.
- A CHIP Perinate will continue to receive coverage through the CHIP program as a "CHIP Perinate Newborn" if born to a family with an income above Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn is eligible for twelve months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven months).
    - A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.
- Eligibility determination made by the administrative services contractor.

Pregnant Teens

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

Verifying Health Plan Eligibility

Providers are responsible for verifying a Member's eligibility, identifying which health plan a Member is assigned to, identifying the name of the assigned Primary Care Provider and verifying covered services and if they require prior authorization for each visit prior to providing care to Members. There are several ways this can be done:

- Member identification cards
- Telephone verification
    - Member Services (local): 682-885-2247
    - Member Services (toll-free): 800-964-2247

- Secure Provider Portal
    - cookchp.org

Cook Children's Health Plan recommends that Providers verify eligibility through all available means prior to providing care to Members.

Pharmacy Providers can verify eligibility electronically through NCPDP E1 Transaction, National Council for Prescription Drug Programs (NCPDP) E1 transaction. The E1 transaction is submitted through the pharmacy's point-of-sale system.

Cook Children's Health Plan Identification Card

The Cook Children's Health Plan CHIP and CHIP Perinate Newborn Member's identification card identifies the Health Plan and Primary Care Provider that has been selected by the Member. The card includes the following essential information:

- Member Name
- Member Identification Number
- Health Plan telephone number
- Primary Care Provider's name and telephone number

While the health plan identification card does identify the Member, it does not confirm eligibility. This is because Member eligibility can change periodically without notice. Providers should use all available resources to confirm current Member eligibility prior to rendering services. Primary Care Providers should not treat any Member whose identification materials identify a different Primary Care Provider or health plan.

An example of a CHIP and CHIP Perinate newborn program Member ID Card is included in the Appendix section of this Provider Manual.

Member Listing for Primary Care Provider

Each Primary Care Provider receives a monthly listing of Members who selected that Provider as their Primary Care Provider. The membership listing is available on our Secure Provider Portal at cookchp.org.

CHIP and CHIP Perinate Newborn Member Rights and Responsibilities

The following is a list of Member rights received upon enrollment with Cook Children's Health Plan:

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other Providers.
2. Your health plan must tell you if they use a "limited Provider network".
    - This is a group of doctors and other Providers who only refer patients to other doctors who are in the same group.
    - "Limited Provider network" means you cannot see all the doctors who are in your health plan.
    - If your health plan uses "limited networks," you should check to see that your child's Primary Care Provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid.
    - Some get a fixed payment no matter how often you visit.
    - Others get paid based on the services they give to your child.
    - You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary.
    - You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other Providers in your health plan and their addresses.
6. You have a right to pick from a list of health care Providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's Primary Care Provider.
    - Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services.
    - Ask your plan about how this works.
10. Your daughter has the right to see a participating Obstetrician/Gynecologist (OB/GYN) without a referral from her Primary Care Provider and without first checking with your health plan.
    - Ask your plan how this works.
    - Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away.
    - Coverage of emergencies is available without first checking with your health

plan.

- You may have to pay a co-payment, depending on your income.
- Co-payments do not apply to CHIP Perinatal Members.

12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other Providers.
16. You have the right to talk to your child's doctors and other Providers in private, and to have your child's medical records kept private.
    - You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child.
    - If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment.
    - Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services.
    - Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have the right to receive information about the organization, its services, its practitioners and Providers and member rights and responsibilities.
21. You have the right to be treated with respect, dignity, privacy confidentiality, and nondiscrimination. That includes the right to:
    - Be treated fairly and with respect.
    - Know that your medical records and discussions with your Providers will be kept private and confidential.
22. You have the right to participate with practitioners in making decisions about your health care.
23. You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
24. You have a right to voice complaints or appeals about the organization or the care it provides.
25. You have a right to make recommendations regarding the organization’s member

rights and responsibilities policy.

Member Responsibilities

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

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

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019**.** You can also view information concerning the HHSC office of Civil Rights online at https://www.hhs.gov/ocr/index.html.

Member's Right to Designate an OB/GYN

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

CHIP Perinate Member (Unborn Child)

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

CHIP Perinatal Program Members are exempt from the ninety day waiting period, the asset test, and all cost-sharing that applies to traditional CHIP Members, including enrollment fees and copays for the duration of their coverage period.

Enrollment

The Texas Health and Human Services Commission is responsible for determining CHIP Program eligibility and makes the final decision of enrollment for all CHIP Members. The mother of the CHIP Perinate has fifteen calendar days from the time the enrollment packet is sent by the Enrollment Broker to enroll in a health plan. If a health plan is not selected within fifteen calendar days of the Member receiving their enrollment packet an automatic assignment will be made.

Newborn Process

- When a Member of a household enrolls in CHIP Perinatal, all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if those health plans are different.
    - All Members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal Member's enrollment period, or (2) the end of the traditional CHIP Members' enrollment period.
    - Copayments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program.
- In the tenth month of the CHIP Perinate Newborn's coverage, the family will receive CHIP renewal form.
    - The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members'

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

Disenrollment

The Health and Human Services Commission makes the final decision of disenrollment for all CHIP Members. Providers may not take retaliatory action against a CHIP Member due to disenrollment. Disenrollment occurs due to loss of eligibility and may be a result of one of the following events:

- When a child turns nineteen.
- Failure to re-enroll at the conclusion of the twelve month eligibility period.
- Enrollment in Medicaid.
- Change in health insurance status (e.g., child enrolling in an employer-sponsored insurance plan).
- Permanent move out of the state.
- Death of a child.

Plan Changes

- A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and will receive twelve months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.
    - A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid eligibility threshold will receive a form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.
- A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate Newborn" if born to a family with an income above Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.
- A CHIP Perinate Newborn is eligible for twelve months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.
- CHIP Perinate mothers must select an MCO within fifteen calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has ninety days to select another MCO.

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

If a CHIP Perinatal Program Member's effective date of coverage occurs while the Member is confined in a hospital, the MCO is responsible for the Member's costs of covered services beginning on the effective date of coverage. If a Member is disenrolled while the Member is confined in a hospital, the MCO responsibility for the Member's costs of covered services terminates on the date of disenrollment.

CHIP Perinatal Members may request to change health plans under the following circumstances:

- For any reason within ninety days of enrollment in CHIP Perinatal
- If the Member moves into a different service delivery area
- For cause at any time

Eligibility Verification

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

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

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

Verifying Health Plan Eligibility

CHIP Perinatal Providers are responsible for verifying a Member's eligibility, verifying covered services and if they require prior authorization and identifying which health plan a Member is assigned to for each visit prior to providing care to Members. There are several ways this can be done: through Member identification cards, telephone verification, and through Cook Children's Health Plan Secure Provider Portal. Cook Children's Health Plan recommends that Providers verify eligibility through all available means prior to providing care to Members. There are several ways this can be done:

- Member identification cards
- Telephone verification
    - Member Services (local): 682-885-2247
    - Member Services (toll-free): 800-964-2247
- Secure Provider Portal
    - cookchp.org

Cook Children's Health Plan Identification Card

The Cook Children's Health Plan CHIP Perinate Member (unborn child) identification card identifies the health plan that has been selected by the Member. The card includes the following essential information:

- Member name
- Member identification number
- Primary HMO's telephone number
- Plan effective date
- Category A or B

While the health plan identification card does identify the Member, it does not confirm eligibility. This is because Member eligibility can change periodically without notice. CHIP Perinatal Providers should use all available resources to confirm current Member eligibility prior to rendering services. Providers should not treat any Member whose identification materials identify a different health plan.

An example of a CHIP Perinatal (unborn child) Program Member ID Card is located in

the Appendix section of this Provider Manual.

CHIP Perinatal Member Rights and Responsibilities Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other Providers.
2. You have a right to know how the perinatal Providers are paid.
    - Some may get a fixed payment no matter how often you visit.
    - Others get paid based on the service they provide for your unborn child.
    - You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a perinatal service is covered or medically necessary.
    - You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other perinatal Providers in the health plan and their addresses.
5. You have a right to pick from a list of health care Providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away.
    - Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other Providers.
10. You have the right to talk to your perinatal Provider in private, and to have your medical records kept private.
    - You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child.
    - If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal Providers can give you information about your or your unborn child's health status, medical care,

or treatment.

- Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities

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

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program 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 that are prescribed.

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

Section 3: Covered Services

MEDICAID (STAR) COVERED SERVICES

Cook Children's Health Plan Medicaid (STAR) Members are entitled to all medically necessary services covered under the Texas Medicaid Program. At a minimum, Cook Children's Health Plan must provide a benefit package to Members that includes fee for service benefits currently covered under the Medicaid program. The following information provides an overview of benefits provided for STAR Members.

STAR Covered Services include Medically Necessary:

- Emergency and non-emergency ambulance services
    - Audiology services, including hearing aids, for adults and children
- Behavioral Health Services, including:
    - Inpatient mental health services for children (birth through age twenty)
    - Acute inpatient mental health services for adults
    - Outpatient mental health services
    - Psychiatry services
    - Mental Health Rehabilitative Services
    - Counseling services for adults (twenty-one years of age 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)
- Birthing services provided by a Physician and 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 provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC
- Hospital services, including inpatient and outpatient
    - The MCO may provide inpatient services for acute psychiatric conditions in a free standing psychiatric hospital in lieu of an acute care inpatient hospital setting
    - The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
    - Inpatient services, outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of 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.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age twenty) through the Texas Health Steps Program, including Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children six months through thirty-five 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
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Primary Care services

- Preventative Services including an annual adult well check for patients twenty-one years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Mental Health Targeted Case Management
- Mental Health Rehabilitative Services
- Therapies - physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses, are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Telehealth

Limitations and Exclusions from Covered Services

Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for a complete listing of limitations and exclusions. The limitations and exclusions can be accessed online at tmhp.com.

Added Benefits

- STAR Members are not limited to the thirty day spell of illness
- $200,000.00 annual limit on inpatient services does not apply for STAR Members
- STAR Members who are twenty-one years of age or older receive unlimited medically necessary prescription drugs

Annual Adult Well-Checks

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

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended

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

Family Planning Services

Family Planning services, including sterilization, are covered STAR Member benefits. These services can be provided by an in network Provider for Cook Children's Health Plan. Family planning services are preventive health, medical, counseling, and educational services that assist Members in controlling their fertility and achieving optimal reproductive and general health. Family planning services must be provided by a physician or under physician supervision.

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

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

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

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) is a Medicaid program that assists a person (children birth through twenty years of age and women with high-risk pregnancies of all ages) in gaining access to medical, social, educational and other service needs related to the person's health condition, health risk or high-risk condition.

Cook Children's Health Plan Service Coordination Supervisor or Manager will review all requests that are submitted to the Health Plan for CPW services.

STAR Members that meet Members with Special Health Care Needs (MSHCN) criteria will have a Cook Children's Health Plan Service Coordinator do outreach for assessment and assistance with accessing medical and social services.

STAR Members that meet Members with Special Health Care Needs (MSHCN) criteria and are requesting a CPW Provider for assistance with accessing educational services related to the Member's health condition, health risk, or high risk condition will be assigned to the CPW Provider of their choice.

STAR Members that meet MSHCN criteria and are requesting a CPW Provider for assistance with accessing medical, social, and educational services related to the Member's health condition, health risk, or high risk condition will be assigned to the CPW Provider of their choice.

If a Provider has not been specified in the request, then the contracted CPW Provider in the nearest zip code to the member will be assigned.

If a CPW service request is submitted to the health plan and the request does not follow the guidelines for CPW services, an outreach phone call will be made to the requester to discuss a solution.

A Member may have both a Service Coordinator and a CPW Provider if the CPW Provider is providing educational services as specified in the guidance. A discussion with the Member's Service Coordinator will take place before a CPW Provider is assigned to ensure there is no duplication of services.

The health plan will work with the Member/LAR to find a solution that honors the Member/LAR preference.

If the requested CPW Provider is not currently contracted with the health plan, an outreach will be made to work with that Provider.

Value Added Services

Value Added Services are extra health care benefits offered by Cook Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services is located on cookchp.org.

Coordination with Non-Medicaid Managed Care Covered Services

STAR Members are eligible for the services described below. Cook Children's Health Plan and our network Providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual.

Texas Health Steps Dental Services (Including Orthodontia)

Primary and preventative dental services for STAR Members are covered from birth through the age of twenty years, except Oral Evaluation and Fluoride Varnish (OEFV) benefits provided as part of a Texas Health Steps Medical checkup for Members age six through thirty-five months. Children should have their first dental checkup at six months of age and every six months thereafter. Services may include but are not limited to medically necessary dental treatment for exams, cleanings, x-rays, fluoride treatment, orthodontia, and restorative treatment. Children under the age of six months can receive dental services on an emergency basis.

- Members are required to enroll in a Medicaid dental plan and main Dentist.
    - Members may self-refer to participating Dentists by contacting their Dental Plan Provider.
    - The Texas STAR Dental Plan Providers are:
        - DentaQuest: 800-516-0165
        - MCNA Dental: 855-691-6262
        - United Healthcare Dental: 877-901-7321
- First Dental Home (FDH)
    - The FDH program is for children from the age of six months through thirty-five months.
    - The purpose of this program is to establish a Dental Home for these children and reduce the incidence of Early Childhood Caries.
    - FDH is offered by Dentists who have been trained and certified by the Department of State Health Services.
    - These children may be seen as frequently as every three months depending on their caries risk.
    - To find a certified FDH Provider for Texas Star Members, contact:
        - DentaQuest: 800-516-0165
        - MCNA Dental: 855-691-6262
        - United Healthcare Dental: 877-901-7321

Texas Health Steps Environmental Lead Investigation (ELI)

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup.

Providers may obtain more information about the medical and environmental management

of lead poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling toll free 800-588-1248 or visiting the webpage at https://www.dshs.texas.gov/lead.

Early Childhood Intervention (ECI)

Early Childhood Intervention Case Management and Service Coordination is a statewide program for families with children, birth to three years old, with disabilities and developmental delays. ECI teaches families how to help their children reach their potential through education and developmental services. Services are provided in the child's natural environment, such as home, daycare, or grandparent's home. Families with children enrolled in Medicaid, or whose income is below two hundred percent of the Federal poverty Level, do not pay for ECI services. Federal law requires Providers to refer children to ECI within two business days of identifying a developmental disability or delay. To make a referral, Providers may call the ECI Care Line toll free 888-754-0524 to identify an ECI program in the Member's area.

For information about ECI resources available to Providers, call:

- Early Childhood Intervention Care Line 888-754-0524
- Cook Children's Health Plan Care Management Department 800-862-2246
- HHSC Early Childhood Intervention Services
- MHMR Tarrant Early Childhood Intervention

A medical diagnosis or a confirmed developmental delay is not needed to refer. As soon as a delay is suspected, Providers may refer a child to ECI even as early as birth. The local program conducts developmental screenings and assesses the child for developmental delay and eligibility. After a child is accepted and enrolled, an individual treatment plan is developed, and services are initiated. When a child is not accepted into the program, ECI staff will refer the family to other resources.

Our network Providers must cooperate and coordinate with local ECI programs to comply with Federal and State requirements relating to the developmental, review and evaluation of Individual Family Service Plan. Medically Necessary Health and Behavioral Health Services contained in an Individual Family Service Plan must be provided to the Member in the amount, duration, scope and setting established in the Individual Family Service Plan.

Early Childhood Intervention Specialized Skills Training

Specialized Skills Training (SST) is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills

for deficits that directly result from medical, developmental, or other health-related conditions.

Specialized Skills Training services are provided by an ECI Provider. The ECI Provider ensures that Specialized Skills Training services are provided by an early intervention specialist who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.313.

Mental Health Targeted Case Management

Targeted Case Management is designed to assist Members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness or a severe emotional disturbance and they are authorized to receive Mental Health Rehabilitative Services. Targeted Case Management requires prior authorization.

Mental Health Rehabilitative Services

Mental Health Rehabilitation Services are defined as 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. Mental Health Rehabilitation Services requires prior authorization.

Texas School Health and Related Services

School Health and Related Services (SHARS) is a Medicaid financing program and is a joint program of the Texas Education Agency and HHSC. The program allows local school districts/shared services arrangements to obtain Medicaid reimbursement for certain health-related services provided to students in special education. School districts/shared services arrangements receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements. These students must:

- Are twenty years of age and younger and be eligible for Medicaid;
- Meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA)
- Have Individual Educational Plans (IEPs) that prescribe the needed services

Covered services include: audiology, counseling, nursing services, occupational therapy,

personal care services, physical therapy, physician services, psychological services, including assessments, speech therapy, and transportation in a school setting. These services must be provided by qualified personnel who are under contract with or employed by the school district.

DARS Blind Children's Vocational Discovery and Development Program (Texas Commission for the Blind Case Management)

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid Provider of case management for clients who are twenty-one years of age and younger and blind or visually impaired.

Any child who has a suspected or diagnosed visual impairment may be referred to Blind Children's Vocational Discovery and Development program. The Department of Assistive and Rehabilitative Services Division for Blind Services assesses the impact the visual impairment has on the child's development and provides blindness specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the Department of Assistive and Rehabilitative Services website dars.state.tx.us.

Blind Children's Vocational Discovery and Development program services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family's needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

Blind Children's Vocational Discovery and Development program services include the following:

- Assisting the client in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management, recreational activities, and grooming
- Supplying information to families about additional resources

Tuberculosis Services provided by the Department of State Health Service – Approved Providers (Directly Observed Therapy and Contact Investigation)

All confirmed cases of Tuberculosis (TB) must be reported to the Local Tuberculosis Control Health Authority (LTCHA) using the most recent Department of State Health Services forms and procedures within one day of diagnosis for a contact investigation. Providers must document Members' referrals to Local Tuberculosis Control Health Authority in their medical records and notify Cook Children's Health Plan of the referrals.

Cook Children's Health Plan must coordinate with the Local Tuberculosis Control Health Authority to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy. Providers must report to Department of State Health Services (DSHS) or the Local Tuberculosis Control Health Authority any Member who is non-compliant, drug resistant or who is or may be posing a public health threat. Cook Children's Health Plan must cooperate with the local Tuberculosis Control Health Authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

Department of Aging and Disability Services Hospice

The Department of Aging and Disability Services (DADS) manages the hospice program. Members are dis-enrolled from Cook Children's Health Plan upon enrollment into hospice. Medicaid hospice provides palliative care to all Medicaid eligible clients who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Services include medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death. When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. The Department of Aging and Disability Services can be contacted a 512-438-3519.

Admissions to Inpatient Mental Health Facilities as a Condition of Probation

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.

A "Court-Ordered Commitment" means a confinement of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C.

Personal Care Services (Members birth through age twenty)

Personal Care Service is a Medicaid benefit that assists eligible clients who require assistance with activities of daily living and instrumental activities of daily living because of a physical, cognitive or behavioral limitation related to their disability or chronic health condition.

Who can receive Personal Care Services?

Individuals who are:

- Younger than twenty-one years of age.
- Enrolled with Texas Medicaid.
- Have physical, cognitive, or behavioral limitations related to a disability, or chronic health condition that inhibits ability to accomplish activities of daily living and instrumental activities of daily living.
- Have parental barriers that prevent the client's parent/guardian from assisting the client.
    - The following needs of the parent/guardian are also considered:
        - The parent/guardian's need to sleep, work, attend school, meet his/her own medical needs.
        - The parent/guardian's legal obligation to care for, support and meet the medical, education, and psychosocial needs of his/her other dependents.
        - The parent/guardian's physical ability to perform the personal care services.
- Client Referrals:
    - A client referral can be provided by anyone who recognizes a client need for PCS including, but not limited to, the following:
        - Client or family Member
        - A primary practitioner, Primary Care Provider, or medical home
        - A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client

DSHS social workers process referrals, assess Members, and submit prior authorizations to TMHP for services. Providers may call the Personal Care Services Referral Line toll free 888-276-0702 for more information.

CHIP and CHIP Perinate Newborn Covered Services

Cook Children's Health Plan is required to provide specific medically necessary services to its CHIP Members. Covered services for CHIP Members must meet the CHIP definition of "Medically Necessary." Medically necessary health services means:

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

- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
- Consistent with the Member's diagnoses;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- Not experimental or investigative; and
- Not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that:
    - Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
    - Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
    - Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    - Are the most appropriate level or supply of service that can be safely provided;
    - Could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
    - Are not experimental or investigative; and
    - Are not primarily for the convenience of the Member or Provider

There is no lifetime maximum on benefits however a twelve month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Cook Children's Health Plan will not impose any pre-existing condition limitations or exclusions to CHIP eligible Members. Please refer to the following websites for the most updated CHIP and CHIP Perinate benefit information:

- HHSC Uniform Managed Care Contract Terms and Conditions
- HHSC CHIP State Plan

Medically necessary services include, but are not limited to, the following:

Covered Services	CHIP Members and CHIP Perinate Newborn Members
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of forty-eight hours following an uncomplicated vaginal delivery and ninety-six hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ○ Dilation and curettage (D&C) procedures; ○ Appropriate Provider-administered medications;

	○ Ultrasounds, and ○ Histological examination of tissue samples. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: ○ All stages of reconstruction on the affected breast; ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ○ Surgery and reconstruction on the other breast to produce symmetrical appearance; and ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas ○ Cleft lip and/or palate; or ○ Severe traumatic skeletal and/or congenital craniofacial deviations; or • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital- based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings

	• Preventive health services
	• Physical, Occupational and Speech therapy
	• Renal dialysis
	• Respiratory services
	  ○ Radiation and chemotherapy
	• Blood or blood products that are not provided free-of-charge to the patient and the administration of these products
	• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ○ Dilation and curettage (D&C) procedures;
	  ○ Appropriate Provider-administered medications;
	  ○ Ultrasounds, and
	  ○ Histological examination of tissue samples
	• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.
	• Surgical implants
	• Other artificial aids including surgical implants
	• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
	  ○ All stages of reconstruction on the affected breast;
	  ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
	  ○ Surgery and reconstruction on the other breast to produce symmetrical appearance; and
	  ○ Treatment of physical complications from the mastectomy and treatment of lymphedemas.
	  ○ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME twelve (12)month period limit
	  ○ Pre-surgical or post-surgical orthodontic services for
	  ○ medically necessary treatment of craniofacial

	anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ cleft lip and/or palate; or • Severe traumatic skeletal and/or congenital craniofacial deviations; or
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in Physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of surgical services, including: ○ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ○ Administration of anesthesia by Physician (other than surgeon) or CRNA ○ Second surgical opinions ○ Same-day surgery performed in a Hospital without an over-night stay ○ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: ○ All stages of reconstruction on the affected breast; ○ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ○ Surgery and reconstruction on the other breast to produce symmetrical appearance; and ○ Treatment of physical complications from the

	mastectomy and treatment of lymphedemas. • In network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: ○ Dilation and curettage (D&C) procedures; ○ Appropriate Provider-administered medications; ○ Ultrasounds, and ○ Histological examination of tissue samples. • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ○ Cleft lip and/or palate; or ○ Severe traumatic skeletal and/or congenital craniofacial deviations; or ○ Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
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.
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP Members.
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	CHIP Members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Twenty thousand dollar twelve month period limit for DME, prosthetic 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.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to:

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

	and home-based) or in a state-operated facility ○ Neuropsychological and psychological testing ○ Medication management ○ Rehabilitative day treatments ○ Residential treatment services ○ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. ○ Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP- CSs shall be Providers working through a DSHS-contracted Local Mental • Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include: ○ individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services Does not require Primary Care Provider (PCP) referral
Inpatient and Residential Substance Abuse Treatment	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization,

Services	and 24-hour residential rehabilitation programs
	• When inpatient and residential substance use disorder treatment services are required as:
	  ○ A court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code;, or
	  ○ As a condition of probation
	• The court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
	• These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2
	
	Does not require Primary Care Provider (PCP) referral

Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following:
	• Prevention and intervention services that are provided by physician and non- physician Providers, such as screening, assessment and referral for chemical dependency disorders.
	• Intensive outpatient services
	• Partial hospitalization
	• Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least ten hours per week for four to twelve weeks, but less than twenty-four hours per day
	• Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training
	• When inpatient and residential substance use disorder treatment services are required as:
	  ○ A court order, consistent with Chapter 462 Subchapter D of the Texas Health and Safety Code or
	  ○ As a condition of probation

	• The court order serves as a binding determination of medical necessity. ○ Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2 Does not require Primary Care Provider (PCP) referral
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age- appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six (6) months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of one hundred-twenty days with a six month life expectancy • Members electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health

	condition • Hospital emergency department room and ancillary services and physician services twenty-four hours a day, seven days a week, both by In network and out-of-network Providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses
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 twelve month period, without authorization • One pair of non-prosthetic eyewear per twelve month period
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to one hundred dollars for a twelve month period limit for a plan-approved program • Health plan defines plan-approved program. May be subject to formulary requirements.

Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and Provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.

DME/SUPPLIES

DME/Supplies are not a covered benefit for CHIP Perinate Members (Unborn Child), with the exception of a limited set of disposable medical supplies, when they are obtained from an authorized pharmacy Provider.

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency, it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by Members highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age four or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	

Basal Thermometer		X	Over-the-counter supply.
Batteries - initial	X		For covered DME items.
Batteries - replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age four or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/ Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment and tape. Many times these items are

			dispensed in a kit which includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/ Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in

			a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For Members who could be sustained on an age-appropriate diet • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than fifty percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age four or over only when prescribed by a

			physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/ Diabetic			See Diabetic Supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/ Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/ sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant.

			Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/ Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the health plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: • When used to dilute medications for nebulizer treatments; • As part of covered home care for wound care • For indwelling urinary catheter irrigation
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, tubes, ties, holders, cleaning kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter and Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the Primary Care Provider (PCP) and approved by the plan.

Urinary, Indwelling Catheter and Supplies	X		Covers catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Covers supplies needed for intermittent or straight cauterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

CHIP and CHIP Perinate Newborn Exclusions from Covered Services

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

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters Band C, 574, Subchapter D or 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by health plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.

- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out of network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section, and services provided by an FQHC, as provided for in Section 8.1.22 of the Contract.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/ Primary Care

Primary (PCP).

- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S., Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

Added Benefits

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

Value Added Benefits

Value Added Services are extra health care benefits offered by Cook Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services is located on cookchp.org.

Coordination with Non-CHIP Covered Services

The following are services that are not a part of Cook Children's Health Plan services; however, Cook Children's Health Members can also qualify for:

- **Texas Agency-Administered Programs and Case Management Services**
    - Early Childhood Intervention Program.
        - ECI can offer services in the home or in the community for children, birth to three years old who are developmentally delayed. Some of the services for children include: screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
    - Department of State and Health Services Targeted Case Management Programs.
        - DSHS can offer various mental health and mental retardation programs, such as psychiatric treatment, child and adolescent counseling, and crisis intervention.
    - Women, Infants, and Children (WIC) Program.
        - WIC can help infants and children under five years old and pregnant and breastfeeding women who qualify to get nutritious food, nutrition education, and counseling.
- **Essential Public Health Services**
    - Cook Children's Health Plan is required by its contractual relationship with HHSC to coordinate with Public Health entities for the provision of essential public health services. Providers must assist Cook Children's Health Plan by:
        - Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by state law;
        - Assisting in notification or referral to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving Members;
        - Referring to the local Public Health Entity for TB contact investigation and evaluation and preventive treatment of persons with whom the Member has come into contact;
        - Referring to the local Public Health Entity for Sexually Transmitted Disease (STD)/Human Immunodeficiency Virus (HIV) contact

investigation and evaluation and preventive treatment of persons with whom the Member has come into contact;
- Referring to WIC services and information sharing;
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure;
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data;
- Working with Dental Contractors on coordination of care protocols as well as for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary dental Covered services
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment

Pharmacy

Role of the Pharmacy

Cook Children's Health Plan Members receive pharmacy services through Navitus, Cook Children's Health Plan's contracted Pharmacy Benefit Manager. Navitus has a statewide network of contracted pharmacies who are enrolled in the Texas Vendor Drug Program (VDP), including all of the major pharmacy chains and VDP enrolled independent pharmacies.

Members have the right to obtain Medicaid and CHIP covered medications from any Cook Children's Health Plan network pharmacy. These pharmacies are located on Cook Children's Health Plan website. Providers and Members can also call Cook Children's Health Plan Member Services department to locate a network pharmacy.

Network pharmacies are required to:

- Perform prospective and retrospective drug utilization reviews
- Coordinate with the prescribing Provider
- Ensure Members receive all medications for which they are eligible
- Ensure adherence to the Medicaid and CHIP Formularies administered through the Texas Vendor Drug Program and the Medicaid Preferred Drug List (PDL).
- The pharmacy must coordinate the benefits when a Member also receives Medicare Part D services or has other benefits

Member Prescriptions

Cook Children's Health Plan covers prescription medications. Our Members can get their

prescriptions at no cost (Medicaid) or with copays (CHIP).

- Members have the right to obtain their prescriptions from any network pharmacy
- Providers should reference the Medicaid and CHIP formularies and Medicaid Preferred Drug List.
- CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a ninety day supply of a drug.

Formulary and Preferred Drug List

The existing Texas Medicaid and CHIP formularies currently utilized by the Vendor Drug Program (VDP) will be adopted. The formulary, along with a list of drugs requiring prior authorization can be found at Texas Vendor Drug Program website at txvendordrug.com. Medicaid and CHIP formularies and Medicaid Preferred Drug List are available for smartphones and on the web at epocrates.com. The Texas Preferred Drug List and the prior authorization criteria to be used for Cook Children's Health Plan Members are available at https://www.txvendordrug.com/formulary/mco-clinical-pa.

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

- Navitus Provider Portal at navitus.com
- Navitus Pharmacy Help Desk 877-908-6023

Pharmacy Prior Authorization

Navitus processes pharmacy prior authorizations for Cook Children's Health Plan. The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and specific prior authorization criteria can be found at the Vendor Drug Website, eProcrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online via navitus.com under the "Providers" section or have them faxed by Customer Care to the prescribers' office. Prescribers will need their NPI and State to access the portal. Providers can fax prior authorization forms to Navitus at 920-735-5312 or call the Prior Authorization Department at 877-908-6023 to submit a prior authorization request over the phone. After hours, Providers will have the option to leave voicemail. Decisions regarding prior authorizations will be made within twenty-four hours from the time Navitus receives the prior authorization request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request. Prior authorization not required on a return prior authorization request form does not mean the service is approved.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior

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

Cancellation of Product Orders

A network Provider that offers delivery services for covered products, such as Durable Medical Equipment (DME), limited home health supplies, or outpatient drugs or biological products must reduce, cancel or stop delivery if the Member or the Member's authorized representative submits an oral or written request. The network Provider must maintain records documenting the request.

Main Dental Home

Dental plan Members may choose their main dental home. 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 six months or older must have a designated main dental home.

Role of Main Dental Home

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

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 contact the Medicaid/CHIP Enrollment Broker's toll free telephone number at 800-964-2777.

Members with Special Healthcare Needs

Cook Children's Health Plan offers enhanced care management for Members with Special Health Care Needs (MSHCN). The enrollment process identifies Members with Special Health Needs. Primary Care and Specialty Care Providers should also notify the Cook Children's Health Plan Care Management Department of covered Members who may qualify for this program. A Member can be classified as a Member with Special Health Care Needs if the answers to the following five questions can be answered 'yes'.

- Does the Member have a serious on-going illness, complex on-going condition or disability?
- Is the illness, condition, or disability one that has lasted for at least twelve months in a row or more, or is expected to last for at least twelve months in a row or more?
- Does the Member's illness, condition or disability cause (or without treatment, can it cause) limits in the Member's ability to function (activities such as walking, talking, running, eating, playing, learning or relating to others); and are these limits not usual for most people his or her age?
- Does the Member's illness, condition, or disability require regular, on-going treatment and review by doctors, therapists, or other trained health care professionals?
- Does the Member need health care or related services more often than most people do his or her age?

Access to Specialists

Members with Special Health Care Needs have direct access to in network specialty Providers. Cook Children's Health Plan does not require authorization or referrals to in network specialty Providers. Prior Authorization is required to out of network specialty Providers. Care Management staff coordinate care and authorize services if the Member's specialist is out of network to assure access until care is appropriately transitioned in network.

Early identification of Members that may benefit from case management is an integral component of the program and begins at the time of enrollment. Cook Children's Health Plan aggressively attempts to identify Members that may benefit from service coordination or case management services through use of the following: claims triggers; Health Needs Risk Assessment; utilization review activities; referrals from Members, families, physicians and community agencies. When a Member is designated as having Member with Special Health Care Needs status, a Care Management team member will contact the Member or their legally authorized representative to discuss covered services, the Member/ legally authorized representative's right to request a specialist as a Primary Care Provider, out of network services applicable to the child's condition if not available In network, the

availability of enhanced care coordination, and referral to community programs or resources. In collaboration with the Member, family, and the Member's health care Providers, the Care Management team member develops a written service plan that meets the Member's health care needs. Referrals to community agencies when appropriate are included in the service plan.

Designation of a Specialist as a Primary Care Provider

Members that have disabilities, special health care needs, chronic or complex health care needs have the right to request a specialist physician as a Primary Care Provider. Members, their legally authorized representative or Primary Care Providers, or the Member's designee may initiate the request. In order to accept such a request, the specialist physician must agree to provide all Primary Care services, (i.e. immunizations, well child care/annual check-ups, coordination of all health care services required by the Member). The Member or their legally authorized representative must also sign the agreement. The Cook Children's Health Plan Medical Director reviews and determines Cook Children's Health Plan approval for Specialist (physician) as Primary Care Provider (PCP). The form to be used for approval of a Specialist to act as a Primary Care Provider is located in the Appendix section of this Provider Manual.

Continuity of Care

Cook Children's Health Plan takes special care to provide continuity in the care of newly enrolled Members whose physical or behavioral health condition could be placed in jeopardy if medically necessary covered services are disrupted, compromised, or interrupted. Upon notification from a Member or Provider of the existence of a prior authorization, Cook Children's Health Plan ensures Members receiving services through a prior authorization from either another health plan or fee for service receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

- Ninety calendar days after the transition to Cook Children's Health Plan
- Until the end of the current authorization period
- Until Cook Children's Health Plan has evaluated and assessed the Member and issued or denied a new authorization

Cook Children's Health Plan allows a pregnant Member past the twenty-fourth week of pregnancy to remain under the care of her current OB/GYN through her postpartum checkup, even if the Provider is out of network. If a Member wants to change her OB/GYN to one who is in the Cook Children's Health Plan network, she is allowed to do so if the Provider to whom she wishes to transfer agrees to accept her care in the last trimester of pregnancy.

Cook Children's Health Plan pays 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 such time as the Member is no longer enrolled in the health plan, whichever is shorter. Payment is made to out of network Providers in the time period required for network Providers. Cook Children's Health Plan complies with out of network Provider reimbursement rules as adopted by the HHSC.

With the exception of pregnant Members who are past the twenty-fourth week of pregnancy, Cook Children's Health Plan does not reimburse a Member's existing out of network Providers for ongoing care for:

- More than ninety days after a Member enrolls in the health plan.
- For more than nine months in the case of a Member who, at the time of enrollment in the health plan, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the health plan.

Cook Children's Health Plan's obligation to reimburse the Member's existing out of network Provider for services provided to a pregnant Member past the twenty-fourth week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Cook Children's Health Plan provides or pays out of network Providers who provide medically necessary covered services to Members who move out of the service area through the end of the period for which capitation has been paid for the Member.

Cook Children's Health Plan provides Members with timely and adequate access to out of network services for as long as those services are necessary and not available within the network. If services become available from a network Provider, Cook Children's Health Plan is not obligated to provide a Member with access to out of network services.

Cook Children's Health Plan ensures that each Member has access to a second opinion regarding the use of any medically necessary covered service. A Member may access a second opinion from a network Provider or out of network Provider if a network is not available, at no cost to the Member.

Providers are encouraged to call the Cook Children's Health Plan Care Management Department at 682-885-2252 or 888-243-3312 for assistance with any continuity of care/ transition of care issues.

Pre-Existing Conditions

Cook Children's Health Plan is responsible for ensuring access to all medically necessary

covered services for each eligible Member beginning on the Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services.

Ambulance Transportation

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

Emergency Ambulance Transportation

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

Facility-to-facility ambulance transports may be considered emergencies if the required 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.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is defined as ambulance transport 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 when the Member has a medical condition such as the use of ambulance is the only appropriate means of transportation.

Non-emergency ambulance transportation services must be prior authorized and coordinated by Cook Children's Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency.

The Provider of record, the Ambulance Provider or those acting on their behalf may request approval for an ambulance by submitting an authorization request. Network Providers should submit a prior authorization request through our Secure Provider Portal. Out of network Provider may refer to the Prior Authorization Request Form located on our website at cookchp.org. Cook Children's Health Plan will provide the approval or denial for the prior authorization to the Requesting Provider and the Ambulance Provider.

The ambulance Provider is responsible for ensuring the prior authorization was approved prior to transport as nonpayment will result without a prior authorization. Retrospective review may be performed to ensure that documentation supports the medical necessity of

the transport if within thirty days of transport.

Non-Emergency Medical Transportation (NEMT) Services

Access2Care

What is Access2Care?

Access2Care provide transportation to covered health care services for Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. Access2Care does NOT include ambulance trips.

What services are part of Access2Care?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members twenty years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a covered health care service. The daily rate for meals is twenty-five dollars per day for the Member and twenty-five dollars per day for an approved attendant.
- Members twenty years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members twenty years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, Access2Care will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children fourteen years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children fifteen - seventeen years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered

health care service is confidential in nature.
If you have a Member you think would benefit from receiving Access2Care, please refer the Member to Access2Care at 844-572-8195 for more information.

CHIP Perinate (Unborn Child) Covered Services

Covered CHIP Perinate (Unborn Child) services must meet the definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits however a twelve month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members. CHIP Perinate Newborns are eligible for twelve months continuous coverage, beginning with the month of enrollment as a CHIP Perinatal.

Covered Services	CHIP Perinate Members (Unborn Child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional services charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component Medically necessary surgical services are limited to services that directly relate

	to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with: • Miscarriage or • A non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • Dilation and curettage (D&C) procedures; • Appropriate Provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Not a covered benefit
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs.Outpatient

	services associated with ○ Miscarriage or ○ Non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • Dilation and curettage (D&C) procedures; • Appropriate Provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples. Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. • Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. • Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. • Laboratory tests are limited to: non-stress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at thirty-two - thirty-six weeks of

	pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; • Repeat antibody screen for Rh negative women at twenty-eight 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 test, human immunodeficiency virus antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between sixteen and twenty weeks); screen for gestational diabetes at twenty-four to twenty-eight weeks of pregnancy; • Other lab tests as indicated by medical condition of client. • Surgical services associated with ○ Miscarriage or ○ A non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
	Physician/Physician Extender Professional Services Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient and outpatient services • Laboratory, x-rays, imaging and

	pathology services including technical component and /or professional interpretation • Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: ○ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. ○ Administration of anesthesia by Physician (other than surgeon) or CRNA ○ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. ○ Surgical services associated with (a) miscarriage or (b) a non- viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) ○ Hospital-based Physician services (including Physician performed technical and interpretive components) ○ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT. • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but

	are not limited to: ○ Dilation and curettage (D&C) procedures; ○ Appropriate Provider administered medications; ultrasounds, and histological examination of tissue samples.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first twenty-eight weeks or pregnancy; • One visit every two to three weeks from twenty-eight to thirty-six weeks of pregnancy; and • One visit per week from thirty-six weeks to delivery More frequent visits are allowed as Medically Necessary. Benefits are limited to: • Limit of twenty prenatal visits and two postpartum visits (maximum within sixty days) without documentation of a complication of pregnancy. • More frequent visits may be necessary for high-risk pregnancies. • High-risk prenatal visits are not limited to twenty visits per pregnancy. ○ Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood

	pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; ○ Hematocrit or hemoglobin repeated once a trimester and at thirty-two - thirty-six weeks of pregnancy; ○ Multiple marker screen for fetal abnormalities offered at sixteen-twenty weeks of pregnancy; ○ Repeat antibody screen for Rh negative women at twenty-eight weeks followed by Rho immune globulin administration if indicated; ○ Screen for gestational diabetes at twenty-four - twenty-eight weeks of pregnancy; ○ And other lab tests as indicated by medical condition of client).
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Services Rendered by a Certified Nurse Midwife or physician in a Licensed Birthing Center	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services are subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first twenty-eight weeks or pregnancy;

	• One visit every two to three weeks from twenty-eight to thirty-six weeks of pregnancy; and
	• One visit per week from thirty-six weeks to delivery.
	
	More frequent visits are allowed as Medically Necessary. Benefits are limited to:
	• Limit of twenty prenatal visits and two postpartum visits (maximum within sixty days) without documentation of a complication of pregnancy.
	• More frequent visits may be necessary for high-risk pregnancies.
	• High-risk prenatal visits are not limited to twenty visits per pregnancy.
	  ○ Documentation supporting medical necessity must be maintained and is subject to retrospective review.
	
	Visits after the initial visit must include:
	• Interim history (problems, marital status, fetal status);
	• Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and
	• Laboratory tests (urinalysis for protein and glucose every visit;
	  ○ Hematocrit or hemoglobin repeated once a trimester and at thirty-two to thirty-six weeks of pregnancy;
	  ○ Multiple marker screen for fetal abnormalities offered at sixteen - twenty weeks of pregnancy;

	○ Repeat antibody screen for Rh negative women at twenty-eight weeks followed by Rho immune globulin administration if indicated; ○ Screen for gestational diabetes at twenty-four to twenty-eight weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment, Prosthetic Devices and Disposable Medical Supplies	Not a covered benefit, with the exception of a limited set of disposable medical supplies and only when they are obtained from a CHIP enrolled pharmacy Provider.
Home and Community Health Services	Not a covered benefit.
Inpatient Mental Health Services	Not a covered benefit.
Outpatient Mental Health Services	Not a covered benefit.
Inpatient and Residential Substance Abuse Treatment Services	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	Not a covered benefit.
Rehabilitation Services	Not a covered benefit.
Hospice Care Services	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to

	those emergency services that are directly related to the delivery of the unborn child until birth. Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit Emergency ground, air and water transportation for an emergency associated with • Miscarriage or • A non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Not a covered benefit.
Vision Benefit	Not a covered benefit.
Chiropractic Services	Not a covered benefit.

Tobacco Cessation Program	Not a covered benefit.
Case Management and Care Coordination Services	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy- dispensed and Provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.

CHIP Perinate (Unborn Child) Exclusions from Covered Services

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies when they are obtained from an authorized pharmacy Provider
- Home and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the labor with delivery of the covered unborn child
- Transplant services
- Tobacco Cessation Programs
- Chiropractic Services
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of Member, and other articles which are not required for the specific treatment related to labor with delivery or postpartum care
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child and services provided by an FQHC, as provided in Section 8.1.22 of the Contract
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy

- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self- administered or provided by a caregiver) (This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

Value Added Benefits

Value added services are extra health care benefits offered by Cook Children's Health Plan above the Medicaid and CHIP benefits. A list of the Value Added Services is located on cookchp.org.

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when medically necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.

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

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

Section 4: Texas Health Steps

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid recipients from birth through twenty years of age.

In Texas, the EPSDT program is known as Texas Health Steps (THSteps). Texas Health Steps is administered by the Department of State Health Services (DSHS). For more information regarding Texas Health Steps services, Providers should refer to the Texas Medicaid Provider Procedures Manual at tmhp.com or the Texas Health Steps website at HHS Texas Health Steps

How Do I Become a Texas Health Steps Provider?

To enroll in Texas Medicaid, Providers must complete and submit the appropriate Texas Medicaid enrollment application, including all required forms as indicated in the application.

There are two ways Providers may enroll:

- To apply online, visit tmhp.com and follow the instructions for completing the online enrollment process.
    - Determine your application type
    - Submit an application
    - Complete the process
- To submit a paper application, you will need to download, print, and complete the application forms.
    - You can access these forms by visiting tmhp.com, select Topics, Provider Enrollment.
        - Select forms under Provider Enrollment section.
    - You can also request an enrollment package from Texas Medicaid & Healthcare Partnership by phone at 800-925-9126 or by mail at:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

For enrollment assistance please contact the Texas Medicaid & Healthcare Partnership Contact Center 800-925-9126 option 2 or send an email to Provider.Enrollment.Mailbox@tmhp.com to request assistance with enrollment

questions.

Texas Health Steps Medical Checkups Periodicity Schedule

Providers are required to administer a complete Texas Health Steps medical checkup for Members from birth through age twenty, in accordance with the Texas Health Steps Periodicity Schedule. Providers can find an updated Texas Health Steps periodicity schedule.

Texas Health Steps must be offered for all new members age twenty and younger who are due, soon due or overdue for checkups or case management services. These services may be performed no later than:

- Fourteen days from the date of enrollment for newborns
- Ninety days from the date of enrollment for all other eligible child members

Documentation of Completed Texas Health Steps Components and Elements

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

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

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

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

measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening

- A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (zero to two years), and blood pressure (three to twenty years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings

3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening Provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
    - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
    - Providers may enroll, as applicable, as Texas Vaccines for Children Providers.
    - For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
    - Anemia screening at twelve months
    - Dyslipidemia Screening at nine to twelve years of age and again eighteen – twenty years of age
    - HIV screening at sixteen – eighteen years
    - Risk-based screenings include:
        - Dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

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

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

Sports physical exams do not qualify as Texas Health Steps checkups.

Exceptions to the Periodicity Schedule

On occasion, a child may require a Texas Health Steps checkup that is outside the schedule. Such reasons for an exception to periodicity include:

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

Exceptions to periodicity must be billed on the CMS-1500 and should comply with the standard billing requirements.

If a Provider other than the Primary Care Provider performs the Exception to Periodicity medical checkup, the Primary Care Provider must be provided with medical record information. In addition, all necessary follow-up care and treatment must be referred to the PCP. Additional information concerning Texas Health Steps can be accessed at tmhp.com.

Texas Vaccines for Children

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled Providers for administration to individual's birth through eighteen years of age. Providers may obtain vaccines free of charge from the Texas Vaccines for Children Program and must not charge the Member for the vaccines. Medicaid does not reimburse for vaccines that are available through TVFC. Providers may refer to the TVFC website at for information about the program and for a list of vaccines available through the program.

ImmTrac2

ImmTrac2, the Texas immunization registry, is a free service from the Texas Department of State Health Services. It is a secure, confidential registry that stores immunization records electronically in one centralized system, available only to authorized users. Texas law requires health care Providers and "payors" (e.g., health insurance companies) to report specified immunization information regarding vaccines administered to children younger than eighteen years of age to the Texas Department of State Health Services. For more information, please visit the ImmTrac2 website at immtrac.tdh.state.tx.us/

Texas Health Steps Billing

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

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps Providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the members life to ensure that health screenings occur at age-appropriate points in a member's life.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, a tuberculin skin test (TST), developmental and autism screening, vaccine administration, and Oral Evaluation and Fluoride Varnish (OEFV).

Children of Migrant Farm Workers

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

checkup.

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

Cook Children's Health Plan will send written notification to Primary Care Providers when Children of Migrant Farm Workers are assigned to their membership listing. For families in need of accelerated services, a representative will facilitate the appointment with the family, Provider's office, and Medicaid Medical Transportation Program (MTP) as appropriate.

Providers should notify Cook Children's Health Plan of a Member when they identify a migrant farm worker or the child of a migrant farm worker by calling 800-964-2247. Representatives are available to assist you from Monday to Friday, 8:00 a.m. - 5:00 p.m. Central Standard Time. This will allow Cook Children's Health Plan to complete an assessment to better coordinate and accelerate services for that Member.

Oral Evaluation and Fluoride Varnish Benefits

Oral Evaluation and Fluoride Varnish Benefits (OEFV) are provided as part of a Texas Health Steps medical checkup for Members aged six months through thirty-five months of age.

Texas Health Steps enrolled physicians, physician assistants, and advanced practice registered nurses are eligible to provide OEFV services. Providers must attend an OEFV training offered by the Department of State Health Services Oral Health Program to become certified to bill for this service. All other medical team members are encouraged to attend the training.

Completion of this course does not certify you to bill Medicaid for oral evaluations and fluoride varnish. If you are a Physician, Physician's Assistant, or Advanced Practice Nurse and wish to receive certification to perform this service and bill Medicaid, you must provide additional certification information. The certification code is placed on the Texas Health Steps TPI under which the Provider bills their Texas Health Steps medical checkups.

Oral Evaluation and Fluoride Varnish Benefits includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

1. OEFV is billed by Texas Health Steps Providers on the same day as the Texas Health Steps medical checkup.
2. OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.

3. Documentation must include all components of the OEVF.
4. Texas Health Steps Providers must assist Members with establishing a Main Dental Home and document Member's main dental home choice in the Member's file.

Outreach

Cook Children's Health Plan representatives will contact new Members under the age of twenty-one that are due a Texas Health Steps medical checkup. Through outreach, new Members are educated about the importance of receiving timely Texas Health Steps medical checkups, the periodicity schedule, and any questions that they may have about the services their child can receive. Outreach assists with scheduling appointments by facilitating three way conference calls with Providers and the Medicaid Medical Transportation Program as needed.

Section 5: Claims and Billing

Statutory Requirements

Cook Children's Health Plan follows the authority of the following entities for claim processing requirements and timelines:

- Health and Human Services Commission (HHSC)
- Texas Medicaid Provider Procedures Manual (TMHP)
- Texas Department of Insurance (TDI)
- National Correct Coding Initiative (NCCI) Edits
- Centers for Medicare and Medicaid Services (CMS)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual at tmhp.com prior to rendering services. Always refer to the most recent publication.

In addition, prior to submitting services for reimbursement Providers should refer to the most recent publications of the:

- Cook Children's Health Plan Provider Manuals located on cookchp.org
- Electronic Data Interchange Requirements located on tmhp.com and cookchp.org
- CPT, ICD-10, HCPC coding books
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- National Correct Coding Initiative Edits located on cms.gov and medicaid.gov

Clean Claim Information

A clean claim has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment. A Provider submits a clean claim by providing the required data elements on the standard claim form.

Claim Filing Deadline

Claims must be received by Cook Children's Health Plan within ninety-five days from the date of service. If a claim is not received within ninety-five days of the date of service, the claim will be denied.

Filing Deadline Calendar

Cook Children's Health Plan follows the most current filing deadline calendar located on the Texas Medicaid & Healthcare Partnership website at tmhp.com.

Prompt Payment Requirements

Clean claims are adjudicated in adherence to the following performance requirements and timeframes set by the Texas Health and Human Services Commission:

1. Ninety-eight percent of all clean claims within thirty days of receipt (whether paper or electronic).
2. Ninety-nine percent of all clean claims within ninety days of receipt.
3. Ninety-eight percent of all appealed claims within thirty days of receipt.
4. One hundred percent of all claims, including appealed claims, within twenty-four months from date of service.

Timeframes are based on calendar days and are subject to change due to updates in HHSC requirements, federal and state laws, rules, or regulations.

Cook Children's Health Plan is subject to remedies, including liquidated damages and reasonable attorney fees and taxes, if it fails to process and finalize clean claims or a portion of a clean claim within the statutory thirty day timeframe and performance requirements. This interest rate is calculated at an annual eighteen rate, accrued daily, for the period of time the clean claim remains unadjudicated. If the Provider agreement specifies a contracted penalty rate, then that provision controls and the Provider must be paid the contracted penalty rate.

Electronic Claim Submission

All Providers are encouraged to file claims electronically. Cook Children's Health Plan uses Availity as our electronic data interchange clearinghouse. Our partnership with Availity allows Providers to submit single claim submissions at no cost. Providers may contact Availity Client Services at 800-282-4548 or access the Availity portal at availity.com.

Product	Clearinghouse	CCHP Payer ID	Contact Phone
CHIP	Availity	CCHP1	800-282-4548
STAR	Availity	CCHP9	800-282-4548

Submission of a claim to the clearinghouse does not guarantee that the claim was received by Cook Children's Health Plan. Providers are responsible for monitoring their error reports.

If applicable, Providers submit the appropriate NPI(s) and Taxonomy code(s). Providers must use the NPI and Taxonomy code combination as enrolled and attested with Texas Medicaid. Claims with incorrect, invalid or missing NPI and Taxonomy code combinations will reject or deny.

Pharmacy Claim Submission

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

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

Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Cook Children's Health Plan for payment consideration by referring to their Accepted and Rejected reports. Providers may confirm receipt of submitted claims through our Secure Provider Portal located on our website at cookchp.org. Providers must also track claim submissions against their claims payments to detect and correct all claim errors. Claims that are rejected or denied must be corrected and resubmitted within timely filing guidelines for payment consideration.

Some of the most common reasons for electronic professional claim rejections or denials are:

- Member information does not match – the name, date of birth, sex, and nine-digit Medicaid/CHIP identification number must be an exact match with the Member's identification number
- Missing, incorrect or invalid NPI(s) or Taxonomy code(s), Providers must use the appropriate NPI(s) and Taxonomy code combination as enrolled and attested with Texas Medicaid

- Invalid type of service or invalid type of service/procedure code
- Other health insurance payment information is missing

After filing a claim we recommend Providers check claim status within two weeks via our Secure Provider Portal located on our website cookchp.org.

Paper Claims Submission

Cook Children's Health Plan discourages paper transactions. Should you find that you can only submit a claim on paper we accept the following original red claim forms:

- Institutional of facility paper claim submissions:CMS-1450 (UB-04)
- Professional claim submissions: CMS-1500 (HCFA-1500)

STAR (Medicaid), CHIP, CHIP Perinate (Unborn Child) and CHIP Perinate Newborn Member claims should be mailed to:

Cook Children's Health Plan
Attention: Claims Department
P.O. BOX 21271
Eagan, MN. 55121-0271

Claims for Vision Services (routine and therapeutic services) are reimbursed through National Vision Administrators and are mailed to:

National Vision Administrators
Attention: Claims Department
P.O. Box 2187 Clifton, NJ
07015-2187

When filing a claim, Providers must use the National Provider Identifier and Taxonomy code combination as enrolled and attested with Texas Medicaid. Claims with incorrect, invalid or missing NPI and Taxonomy code combinations will reject or deny.

Electronic Funds Transfers and Electronic Remittance Advices

Providers must enroll in Electronic Funds Transfer (EFT) to receive payments electronically through direct deposit. To enroll in EFT, please visit the Electronic Submission Services page located on our website cookchp.org.

Electronic Remittance Advice (ERA) files are available through Availity. To enroll for ERA

delivery visit Availity.com or for assistance contact Availity Client Services at 800-282-4548.

Claim Status Assistance Secure Provider Portal

To check claim status online you must register for access to our Secure Provider Portal located on our website cookchp.org.

Provider Support Services

Cook Children's Health Plan claim representatives are available to assist with claim inquiries at 888-243-3312.

Provider Reimbursement

Cook Children's Health Plan will reimburse Providers according to their contractual agreement. The health plan cannot reimburse Providers for Medicaid services unless the Provider is enrolled with Texas Medicaid & Healthcare Partnership and is included on the state master file.

Reimbursement will issued to Providers who render medically necessary covered services to eligible Members, for whom a capitation has been paid to Cook Children's Health Plan. To verify a covered service please contact Cook Children's Health Plan at 888-243-3312.

Claim Documentation Requirements

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

- Providers must use the National Provider Identifier(s) and Taxonomy code(s) combination as enrolled and attested with Texas Medicaid. Claims with incorrect, invalid or missing NPI and Taxonomy code combinations will reject or deny (example: Referring, Ordering, Rendering, Supervising, Billing and Service Facility Provider(s)).
- National Drug Code - The National Drug Code (NDC) is an eleven digit number on the package or container from which the medication is administered. All Providers must submit a National Drug Code for professional or outpatient claims submitted with a physician administered prescription drug procedure. The description, unit of measure and unit quantity must be included in the claim. Claims that do not have this information ~~will~~ may be rejected or denied. For additional NDC billing guidelines

please refer to the Texas Medicaid Provider Procedures Manual found on the Texas Medicaid & Health Partnership website at tmhp.com.

- Newborn Members without Medicaid or CHIP ID Numbers - If a Medicaid or CHIP eligible newborn has not been assigned a number on the date of service, the Provider must wait until the identification number is assigned to file the claim. The Provider must submit the claim with the Member identification number. Providers must check eligibility regularly to ensure claims are received within the required ninety-five day filing deadline.

Cook Children's Health Plan will provide at least ninety day notice prior to implementing change in the claims guidelines unless the change is required by statute or regulation in a shorter timeframe.

Coordination of Benefits

Medicaid is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid.

All other available third party resources must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of a Medicaid Member. Providers must submit claims to other health insurers for consideration prior to billing Cook Children's Health Plan.

Cook Children's Health Plan
Attention: Claims Department
P.O. BOX 21271
Eagan, MN. 55121-0271
Email: CCHPCOB@cookchildrens.org

If Cook Children's Health Plan is aware of other third party resources at the time of claim submission and the billing Provider is not, the claim will deny and the Explanation of Payment will instruct the Provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, Cook Children's Health Plan will pursue post payment recovery.

Providers have access to verify Coordination of Benefits through the Secure Provider Portal located on our website at cookchp.org. Providers may submit supporting documentation regarding the termination of primary carrier benefits (making sure to include termination date and/or Explanation of Payment (EOP) showing denial of claim via the Secure Provider Portal or by email to CCHPCOB@cookchildrens.org. In cases where the other payer makes payment, the claim must include the subscriber, payer and payment

information. If this information is not included the claim will deny.

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

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

Overpayments

An overpayment is any payment that a Provider receives in excess of the amount payable for a service rendered. When an overpayment is identified by Cook Children's Health Plan, the refund request process is initiated. The Provider will receive written notification making them aware that an overpayment has been made in error. Providers have thirty days from the date of the letter to respond to Cook Children's Health Plan. Failure to refund or respond to a request may result in an offset against future claim payments until the amount of the overpayment has been fully recovered. If the Provider determines the request is inaccurate, the Provider should contact Cook Children's Health Plan at 888-243-3312.

To ensure the refund request is applied correctly, Providers should include a letter of explanation or the refund request letter and the Explanation of Payment. Providers can submit refund checks to:

Cook Children's Health Plan
Attention: Finance Department
P.O. Box 2488
Fort Worth, TX 76113-2488

When an overpayment is identified by the Provider due to a billing error, the Provider should submit a corrected claim. The health plan will process the corrected claim and will recoup the overpayment.

When an overpayment is identified by the Provider due to a health plan processing error, the Provider should submit a claim appeal via the Secure Provider Portal requesting reconsideration and recoupment if appropriate.

Corrected Claims Process

A corrected claim is a correction or a change of information to a previously finalized claim. Corrected claims must be received by the health plan within ninety-five days of the date of service.

If submitting electronically:

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

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an adjustment claim as follows: "7" – REPLACEMENT (Replacement of Prior Claim)
2. In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic remittance advice. Example: Claim Frequency Code CLM*12345678*500***11::7**Y*A*Y*I*P~REF*F8*(Enter the Claim Original Reference Number) REF01 must contain 'F8' REF02 must contain the original Cook Children's Health Plan claim number
3. In the 2300 Loop, the NTE segment (free-form 'Claim Note'), must include the explanation for the Corrected/Replacement Claim.NTE01 must contain 'ADD' NTE02 must contain the free-form note indicating the reason for the corrected replacement claim. Example: NTE*ADD*CORRECTED PROCDURE CODE ON LINE 3

For more information, please refer to the EDI Companion Guides on tmhp.com.

If submitting by mail:

- A corrected CMS-1500 (HCFA) or CMS-1450 (UB-04) claim form is required
- Each corrected claim must include: a copy of the EOP and any other attachments needed if applicable
- Corrected claims must be received within five days of the date of service to meet the timely filing requirements
- Provider should notate "Corrected Claim" on a paper CMS-1500 or CMS-1450 (UB-04)
- The UB-04 type of bill code (field four four) shall include a seven in the third position to indicate the claim is a corrected claim.
- Submit corrected claims via EDI or mail to:

Cook Children's Health Plan
Attention: Claims Department
P.O. BOX 21271
Eagan, MN. 55121-0271

Please note: A written or online appeal is not necessary for corrected claims.

Federally Qualified Health Centers and Rural Health Centers

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are reimbursed their assigned encounter rate for general medical services. FQHCs and RHCs must bill a T1015 procedure code and the applicable modifier for general medical services. For more information, Providers should refer to the Texas Medicaid Provider Procedures Manual located at tmhp.com.

To ensure Cook Children's Health Plan has the correct encounter rate, Providers should forward new encounter rate letters to the Network Development Department by email at CCHPNetworkDevelopment@cookchildrens.org.

Medicaid & CHIP Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity. Failure to use modifier TH may result in recoupment of payment rendered.

Prenatal and postpartum care visits billed in an inpatient hospital are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or cesarean section and should not be billed separately.

One postpartum care procedure code may be reimbursed per pregnancy for Medicaid Members. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy, regardless of the number of postpartum visits provided. Procedure code 59430 may be reimbursed once per pregnancy for Medicaid Members following a delivery if the delivery procedure code does not include postpartum care. Since delivery procedure codes 59410, 59515, 59614, and 59622 include postpartum care, procedure code 59430 will be denied if procedure codes 59410, 59515, 59614, or 59622 were submitted by any Provider for the same pregnancy.

Failure to submit a postpartum encounter claim when billing 59410, 59515, 59614, and

59622 (which includes postpartum care) may result in recoupment.

Ultrasound of the pregnant uterus is a benefit when medically indicated. Ultrasound of the pregnant uterus is limited to three per pregnancy. The initial three claims paid for obstetric ultrasounds do not require prior authorization. If it is necessary to perform more than three obstetrical ultrasounds on a Member during one pregnancy, the Provider must request prior authorization with documentation of medical necessity.

Please refer to the Texas Medicaid Provider Manual Procedures Manual at tmhp.com for additional information on Obstetrics and Prenatal Care.

CHIP Perinatal Postpartum Billing

The CHIP Perinatal Member (Unborn Child) eligibility will term on the last day of the month immediately after she delivers. CHIP Perinatal Members are eligible for two postpartum care visits per pregnancy within sixty days. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided. Procedure code 59430 may be reimbursed twice per pregnancy for CHIP Perinatal Members following a delivery if the delivery procedure code does not include postpartum care.

Failure to submit a postpartum encounter claim when billing 59410, 59515, 59614, and 59622 (which include postpartum care) may result in recoupment.

Emergency Services Claims

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

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

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

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

Special Billing

School Physicals	STAR & CHIP Members Only	These services do not need to be provided by the Member's Primary Care Provider but must be performed by an in network Provider. Claims for these services are billed to Cook Children's Health Plan using diagnosis code: Z02.5
Increased Frame Allowance and Vision Services	STAR & CHIP Members Only	Claims for these services should be filed directly to National Vision Administrators LLC (NVA) and questions on how to file these claims should be directed to NVA at 888-830-5630.

Prepared Childbirth Classes	STAR, CHIP, & CHIP Perinate Members Only	Claims for these services are billed to Cook Children's Health Plan listing the Member's ID Number, name, classes taken and billed amount. This should be sent to Cook Children's Health Plan P.O. Box 21271 Eagan, MN. 55121-0271
Non-Emergency Medical Transportation (NEMT)	STAR	For questions related to billing requirements contact Access2Care at 844-572-8195.

Co-payments

Medicaid Managed Care Members do not have a copayment responsibility.

CHIP Cost Sharing

CHIP Network Providers and out of network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members.

CHIP families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the MCO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost sharing limit for the term of coverage, Cook Children's Health Plan will generate and mail to the CHIP Member a new Member ID card within five calendar days, showing that the CHIP Member's cost sharing obligation for that term of coverage has been met. No cost sharing may be collected from these CHIP Members for the balance of their term of coverage.

Providers are responsible for collecting all Member copayments at the time of service. Copayments that families must pay vary according to their income level. Copayments do not apply, at any income level, to covered services that qualify as well baby and well child care services, preventive services, or pregnancy related services as defined by 42 C.F.R. §457.520 and SSA § 2103(e)(2).

Some Members might have additional group or individual coverage available to them.

When this occurs, Cook Children's Health Plan will coordinate benefits as the secondary insurance payor.

Cook Children's Health Plan has provided the Cost Share Table in Appendix section of this Provider Manual.

Please note: No copayments for Medicaid Members, CHIP Perinatal Members and/or CHIP Perinate Newborn Members and CHIP Members who are Native Americans or Alaskan Natives. No copayments for well and well child services, preventive services, or pregnancy related assistance for CHIP Members.

Billing Members

Cook Children's Health Plan reimburses from the Texas Medicaid & Healthcare Partnership fee schedule. Cook Children's Health Plan Providers have agreed to accept the reimbursement as payment in full for services rendered to Medicaid Members.

Members must not be balance billed for the amount above 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 ninety-five day filing deadline.
- Failure to submit a corrected claim within the ninety-five day filing resubmission period.
- Failure to appeal a claim within the one hundred twenty day administrative appeal period.
- Failure to appeal a utilization review determination within thirty 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 Cook Children's Health Plan Members for a third party insurance copayment. Medicaid Members do not have an out of pocket expense for covered services.

If a Provider furnishes services to a Medicaid HMO Member that are not covered, including services that are not medically necessary, he or she must obtain the Member's signature on a Patient Acknowledgement Form which informs the Member of his or her financial responsibility. The Patient Acknowledgement Form and Private Pay Agreement Form are located in the Appendix section of this Provider Manual.

Providers 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.

Providers are allowed to bill Members if retroactive eligibility is not granted. If the Member does become retroactively eligible, the Member should notify the Provider of his or her change in status. Ultimately, the Provider is responsible for timely filing of Medicaid claims. If the Member becomes eligible, the Provider must refund any money paid by the client when a Medicaid claim is filed.

Member Acknowledgement Statement (Explanation of Use)

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

- The Member requests the specific service or item
- The Provider obtains and keeps a written Member Acknowledgment Statement signed by the Member that states:

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

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

Private Pay Statement

A Provider is allowed to bill the following to a Member without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (i.e., cellular therapy).
- All services incurred on non-covered days because of eligibility or spell of illness limitation.
  - Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days.
  - Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are twenty years of age and younger.
- All services provided as a private pay patient.
  - If the Provider accepts the Member as a private pay patient, the Provider must advise the Member that they are accepted as private pay patient at the time the service is provided and will be responsible for paying for all services received.
  - In this situation, HHSC strongly encourages the Provider to ensure that the patient signs written notification so there is no question how the patient was

accepted.
    - Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the Provider cannot seek payment from an eligible Texas Medicaid client.
- The patient is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively.
    - The Provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted.
    - If the client becomes eligible retroactively, the client notifies the Provider of the change in status.
    - Ultimately, the Provider is responsible for filing timely claims.
    - If the client becomes eligible, the Provider must refund any money paid by the client and file claims to Cook Children's Health Plan or Texas Medicaid for all services rendered.

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

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

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

Out-of-Network Claims Submission

Clean claims for Nonparticipating Providers located in Texas must be received by Cook Children's Health Plan within ninety five days of the date of service. Clean Claims for Nonparticipating Providers located outside of Texas must be received within three hundred sixty-five days of the date of service. To submit claims for services provided to Cook Children's Health Plan 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 non-emergent services except as prohibited under federal or state law for in network or out of network facility and physician services for a mother and her newborn(s) for a minimum of forty-eight hours following an uncomplicated vaginal delivery or ninety-six 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) and CHIP, we reimburse:
  - Out of network, in area service Providers at no less than the prevailing Medicaid fee for service rate, less five percent
  - Out of network, out of area service Providers at no less than one hundred percent of the Medicaid fee for service rate

Section 6: Claim Denials and Appeals

Reconsideration of a Claim Denial

Reconsideration is a second review of a service request when the claim was denied because additional information is needed to adjudicate the claim. This level of review is not an element of the Medicaid or CHIP Appeal or Complaint Processes but provides a means of resolving an administrative or medical necessity denial without accessing the Complaint or Appeal Process. If the denial is upheld, the Provider, Member or Member's representative may pursue the appropriate Complaint or Appeal Process. Example components that a Provider may send for Claim Reconsideration include:

- Change in Member eligibility
- The attachment of a Primary Insurance Explanation of Benefits
- Invoice or MSRP

Submitting a Claim Reconsideration

Request for reconsideration must be submitted in writing and received by the health plan within one hundred twenty calendar days of the printed disposition date on the Explanation of Payment.

Supporting documentation may include but is not limited to:

- Letter from the Provider stating why they feel the claim denial is incorrect (required)
- Copy of the original claim
- Copy of the health plan explanation of payment
- MSRP or invoice
- Primary Insurance explanation of benefits

Providers should submit claim reconsiderations via the Secure Provider Portal located at cookchp.org. Claim Reconsiderations may be faxed to 682-885-8404 or mailed to:

Cook Children's Health Plan
Attention: Claim Reconsideration
P.O. Box 2488
Fort Worth, TX 76113-2488

Note: Changes or errors in CPT codes are not available for claim reconsideration. Corrected claims should be submitted to the health plan with a notation of corrected claim.

Appealing a Claim Denial

A Claim Appeal is defined as a written request by the Provider to further consider the original claim reimbursement decision **based on the original claim information received.**

Providers should make the initial attempt to resolve a claim issue by calling Cook Children's Health Plan Claims Department at 888-243-3312. A Provider may appeal any disposition of a claim. An appeal is a claim that has been previously adjudicated as a clean claim and the Provider is appealing the disposition through written notification to the health plan in accordance with the appeal process.

All appeals of denied claims must be received by Cook Children's Health Plan within one hundred twenty days from the date of disposition (the date of the Explanation of Payment on which the claim appears). Payment is considered to have been paid on the date of issue of a check for payment and its corresponding Explanation of Payment (EOP) to the Provider by the health plan, or the date of electronic transmission if payment is made electronically. Any appeal received after the above stated timely filing day period will be denied for failure to file an appeal within the required time limits. Resolution should be received within thirty calendar days from our receipt of the written appeal.

Telephone communication related to the Provider appeal will be documented on an appeal communication log. Email and fax documentation related to the appeal will be retained by the health plan for period of seven years.

Submitting a Claim Appeal

Provider appeals must be submitted in writing and received by the health plan within one hundred twenty calendar days of the printed disposition date on the Explanation of Payment. Supporting documentation may include but is not limited to:

- Letter from the Provider stating why they feel the claim payment is incorrect (required)
- Copy of the original claim
- Copy of the health plan explanation of payment
- Explanation of payment from another insurance company
- Prior authorization number and/or form or fax documenting the prior authorization

determination

- Eligibility verification documentation
- Electronic acceptance reports confirming the claim was received by the health plan
- Overnight or certified mail receipt as proof of filing received date by the health plan

Providers should submit appeals online via the Secure Provider Portal located at cookchp.org. Complete the Customer Service request by selecting the Topic: Submit a Claim Appeal; supporting documentation can be uploaded using the add files feature. Written appeals may be faxed to 682-885-8404 or mailed to:

Cook Children's Health Plan
Attention: Appeals
P.O. Box 2488
Fort Worth, TX 76113-2488

Note: Changes or errors in CPT codes are not considered payment appeals. Corrected claims should be submitted to the health plan with a notation of corrected claim.

No Retaliation

Cook Children's Health Plan will not retaliate against any person filing a complaint against the health plan or appealing a decision made by the health plan.

Section 7: Care Management

Cook Children's Health Plan's Care Management and Service Coordination Program encompasses:

- Medical Management (utilization management, case management/service coordination disease/population health management)
- Population Management (predictive modeling, risk assessments/health screenings, preventive care reminders)

The Care Management/Service Coordination program leverages the integration of all program functions to deliver a "Member-centric" model of care management.

Population Health Management Programs

Cook Children's Health Plan offers Population Health Management programs to meet the needs of every Member. Members are identified through continuous case finding methods, including but not limited to:

- State enrollment files
- Medical management program referral (i.e., utilization review)
- Discharge planner referral
- Member or caregiver referral
- Practitioner referral
- Health needs assessments and health appraisals
- Claims data (medical, behavioral and pharmacy)

As a Member's needs evolve over time, they may transition to a higher level of intervention in a program or to another Population Health Management program (i.e., complex case management) that offers more intensive interventions to address the Member's needs.

Upon identification of a Member for enrollment in a Population Health Management program, program staff inform the Member by interactive contact on how they became eligible for the program/service, how to use program services and how to opt-out. Interactive contact with the Member occurs through one of the following methods:

- Telephone
- In-person contact
- Online contact
    - Interactive web-based module
    - Secure email

- Video conference

Contact information for Referrals

To refer a Member who may qualify for a Population Health Management program or speak to program staff, call 800-964-2247, Monday through Friday from 8:00 a.m. - 5:00 p.m. confidential voicemail is available twenty-four hours a day.

Health Promotion

To help our Members achieve optimal health and improve health related behaviors and quality of life, we offer comprehensive care management programs that meet the needs of all Members of our health plan. Educational materials are available to our Members in multiple formats. Cook Children's Health Care System offers community courses for the parents of our child Members as well as their family members. Regularly scheduled classes include cardiopulmonary resuscitation, asthma management and classes for parents of children with special needs. The Matustik Family Health Library, a family health library, is an excellent resource for our Members and their families. Librarians are available to assist with research. For our adult Members (eighteen years and older), we provide a web-based wellness platform, which includes interactive self-management tools that provide information on the following topics:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Case Management/Complex Case Management

Our case management programs offer a continuum of services. We enroll our Members with the highest health complexity in our Complex Case Management Program, which provides the most intensive interventions. These programs reduce barriers to Members' access to care and treatment plan adherence through assessments to identify their unmet needs and assisting them in getting needed services. Assistance may include care coordination, providing disease/condition specific self-management education, assisting with accessing community resources or other services to address their unmet needs. Member participation in case management programs are voluntary. Program staff must obtain Member consent prior to enrollment.

Program Scope

- Member identification for program enrollment
- Initial comprehensive needs assessment and ongoing assessment
- Person-centered, problem-based comprehensive care plan development, including measurable, prioritized goals and interventions
- Care coordination with the Member's health care team
- Monitoring of the effectiveness of the care plan through ongoing communication with a Member and their Providers
- Satisfaction and quality of life measurement
- Program evaluation using quantitative and qualitative data on at least an annual basis

Comprehensive Case Management Assessment

A Member who is eligible for case management services is assigned a personal case manager, either a licensed nurse or social worker. The case manager contacts the Member to conduct a comprehensive needs assessment, including but not limited to:

- Medical condition
- Cognitive status
- Functional status
- Social determinants of health (SDOH)
- Caregiver support and health
- Mental health conditions and substance use disorders
- Current services
- Unmet service needs
- Member strengths and goals
- Depression screening
- Quality of life

The case manager obtains information from other sources, including the Member's Primary Care Provider and other members of their healthcare team, to develop an individualized, comprehensive care plan.

Members with Special Health Care Needs and Service Management

Members with Special Health Care Needs (MSHCN) means a Member who:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or anticipated to last for a significant period of time, and
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel of Members with Special Health Care Needs are:
    - Members diagnosed with asthma, diabetes, congestive heart failure,

sickle cell disease, chronic renal failure, HIV/AIDS, neuromuscular degenerative diseases (e.g., multiple sclerosis, muscular dystrophy) and cancer.
    - Members receiving ongoing therapy services, including physical therapy, occupational therapy and speech therapy for longer than six months.
    - Members receiving long-term support services through Personal Care Services, Private Duty Nursing, Community First Choice or Prescribed Pediatric Extended Care Center.
    - Pregnant women who have a high risk pregnancy including:
        - Age sixteen and younger, or age thirty-five and older
        - Diagnosed with preeclampsia, high blood pressure or diabetes
        - Diagnosed with mental health or substance use disorders
        - Previous history of pre-term birth
- Members with mental illness and substance use disorder
- Members with behavioral health issues, including substance use disorder or serious emotional disturbance or serious and persistent mental illness (SPMI) that may affect physical health or treatment plan adherence
- Members with high-cost catastrophic cases or high service utilization (e.g., high volume of emergency department visits or inpatient admissions)
- STAR Kids Members

Members also may request to be assessed to determine if they meet the criteria for Members with Special Health Care Needs. For Members identified as Members with Special Health Care Needs, we provide service management, including the development of a service plan, to ensure they receive covered services as well as other support services to meet their needs. Members with Special Health Care Needs have access to treatment by a multidisciplinary team when needed. Members with higher health complexity receive case management services that includes a comprehensive care plan to address their more complex needs. Participation in service management is voluntary, and a Member may opt-out at any time. A Member must consent to receiving service management prior to enrollment in the program. A Member who consents to service management is assigned a personal service manager to assist them.

Disease Management

Disease Management services are designed to assist physicians and other health care providers in managing members with chronic conditions. Disease Management services utilize a member-centric, holistic approach. We tailor our Disease Management interventions based on a Member's risk factors, including social determinants of health that impact a Member's ability to access care or adhere to their treatment plan. Currently we offer Disease Management programs for our Members with asthma, diabetes and perinatal depression.

Our Disease Management program model includes:

- Proactive identification of Members for enrollment in a Disease Management program
- Evidence-based national guidelines as the foundation of each program's design
- Utilization of the Patient Activation Measure® (PAM®), a validated tool which assesses whether a Member has the knowledge, skills and confidence to manage their health and health care
- Interventions tailored to individual Member needs
- Self-management education tailored to the Member's activation level
- Ongoing communication and collaboration with a Member's physician and service providers in treatment planning for a Member
- Individual and program outcomes measurement
- Registered Nurse Disease Management case managers and Certified Community Health Workers

Members have the right to opt-out of a Disease Management program at any time. If a Member elects to opt-out of a Disease Management program, their other benefits are not affected. Before enrolling a Member into a Disease Management case management level of intervention, the Member must consent to receiving case management services.

Baby Steps Program

Our Baby Steps is a proactive care management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through the following methods:

- Review of state enrollment files
- New Member telephonic screenings
- Medical management program referral (e.g., utilization review)
- Discharge planner referral
- Member or caregiver referral
- Practitioner referral

Once Members are identified, we initiate telephonic outreach within five business days to assess obstetrical risk and ensure the Member's enrollment in the appropriate intervention level of the Baby Steps program. All Members enrolled in the Baby Steps program receive written information about Baby Steps program services, how to use the services, a copy of the Baby Basics Book (available in English and Spanish) from the What to Expect Foundation, information about Text4Baby (free text messages on their cell phones through their pregnancy and the baby's first year of life), and Helpful Resources for Women Resource List. Experienced nurse case managers enroll Members with the highest risk in case management with Member consent. Case

managers work with Members and their Obstetrical (OB) Providers to develop a care plan to ensure they have access to necessary services. Our high risk OB case management program offers:

- Individualized, one-on-one case management support.
- Care coordination support.
- Educational materials and information on community resources.
- Incentives to keep prenatal and postpartum checkups and well-child visits after the baby is born.
- Depression screening (Edinburgh Postnatal Depression Scale) and referral to behavioral health Case Manager or Care Coordinator, if appropriate, as well as the appropriate treating Provider.

Service Coordination Description

Cook Children's Health Plan practices under the Cook Children's Health Care System compass. The integration of all program functions are leveraged to deliver a truly "Member-Centric" model of care coordination that is built upon the Institute for Health Care Improvement (IHI), 2007, Triple Aim Framework which includes:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Cook Children's Health Plan has adopted a Care Management model of practice to assist members with navigating through a health delivery system that can be cumbersome and difficult. Care Management serves to address any barriers to care that impact a member's health and quality of life by focusing on assuring that Members receive the right care at the right time in the right place. This focus prevents duplication and waste of health care resources.

Members, as well as their caregivers, are empowered to become their own advocates in a complex and uncertain health care environment. Our staff uses their training and experience to understand the members' needs and empower them to make the best health care choices, especially when they face uncertain situations that affect their ability to care for themselves.

Within the Service Coordination program operations, Cook Children's Health Plan places emphasis on improving outcomes through addressing health literacy, social, behavioral and physical determinants of health, barriers to care, coordination of services and resources, as well as transition planning. These activities and interventions allow the health plan to reach beyond the isolated delivery of health care in order to assist Members to regain optimum health or to improve their overall functional capability.

The Service Coordination Programs focus on empowering a Member in managing the member's safety and member outcomes across care settings. Program services are designed to address the needs of Members who have multiple chronic medical conditions, behavioral health conditions, and/or multiple Potentially Preventable Hospital Admissions (PPAs) or Potentially Preventable Emergency Room Visits (PPVs). A Member's needs may include, but are not limited to:

- Self-management education.
- Care coordination.
- Assistance with navigating the health care system and transitions in care.
- Assistance with addressing identified barriers to treatment plan adherence (e.g., SDOH).

Role of Service Coordinator

Service Coordinators, which include Nurses (RN), Social Workers (LMSW, LCSW), Behavioral Health Specialists (LMSW, LCSW, LPC), and Community Health Workers (CHW), outreach to Members who meet criteria for program eligibility and are referred to Service Coordination. The Service Coordinator completes a comprehensive health risk assessment, including depression screening (if Member is age twelve or older and was not screened prior to referral) and Social Determinants of Health (SDOH) to identify any needs and/or barriers to their person-centered treatment plan that a Member may have. After completing the assessment, Service Coordination services are offered to the Member. When a Member consents to receiving Service Coordination services, Member is enrolled into the best-suited program. The Service Coordinator works with the Member and their care team in a person-centered approach to create a Service Plan that includes goals chosen by the Member to address the Member's identified needs, barriers, and applicable personal goals. Through ongoing contact with the Member, the Service Coordinator continues to work with the Member to evaluate the effectiveness of the Service Plan and make revisions when necessary.

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. Service Coordination should consider and address the Member's situation as a whole, including his or her medical, behavioral, social, and educational needs.

Service Coordination must be used to:

- Provide a holistic evaluation of the Member's individual dynamics, needs and preferences
- Educate and help provide health-related information to the Member, the Member's legally authorized representative (LAR), and others in the Member's support network

- Help identify the Member's physical, behavioral, functional, and psychosocial needs
- Engage the Member and the Member's LAR and other caretakers in the design of the Member's Service Plan/Care Plan
- Connect the Member to covered and non-covered services necessary to meet the Member's identified needs
- Monitor to ensure the Member's access to covered services it timely and appropriate
- Coordinate covered and non-covered services
- Intervene on behalf of the Member if approved by the Member

Service Coordination Program Services

All STAR and CHIP MSHCN meet the triggers for and qualify for Service Coordination services, which includes varying levels of intervention, and must be referred to the Service Coordination department for further assessment. Referrals are triaged and assigned to either a Case Manager or Community Health Worker, depending on member's initially identified complexity. Once assigned, the Service Coordinator will review member's clinical information, and attempt to interview the member/LAR to find out more information, in order to confirm MSHCN status and to determine appropriate level of care. If member or LAR accepts ongoing Service Coordination services when offered, the assigned Service Coordinator enrolls member into the best-suited program and a Service Plan is developed.

Cook Children's Health Plan recognizes that risk factors can increase or decrease at any time. Members may move up and down the spectrum of risk tiers and transition to a different program as time goes by and needs change (e.g. a new injury or acute illness presents or exacerbation of a condition becomes prevalent and the member requires a higher frequency of intervention). Members may be enrolled in one of the following programs with interventions directed at reducing risks:

Service Coordination

Service Coordination (formerly referred to as Service Management) is the lowest level of care provided to members identified as MSHCN and who accept enrollment in ongoing Service Coordination services. Members receiving this level of care have been identified as having lower health complexity.

Disease & Condition Management

Disease and Condition Management addresses the needs of members with chronic condition(s) across all lines of business (STAR and CHIP). Members enrolled in this

program have been diagnosed with Asthma, Diabetes, ADHD, High Risk Maternity, or other Maternity conditions (including postpartum and maternal depression). Disease and Condition Management interventions include specific condition monitoring, coaching, education, and behavioral strategies.

Case Management

Case Management is a higher level of care for members identified as MSHCN who have moderate physical and/or behavioral health complexity, but do not meet criteria for disease/condition management or complex case management.

Complex Case Management

Complex Case Management is the highest level of care and includes members who have severe physical and/or behavioral health complexity and who are at highest risk for multiple, complex, catastrophic, and/or high cost utilization condition(s). These members may require assistance with managing/coordinating multiple health care services and have numerous unmet needs which may also require extensive resources. Their case may be further complicated by behavioral health co-morbidities as well as potentially challenging social situations.

Service Coordinators performing this level of intervention adhere to the most current version of the Case Management Society of America's Standards of Practice for Case Management, as well as National Committee for Quality Assurance and all laws and regulations pertaining to the confidentiality of member protected health information.

Care Coordination

This level of intervention is short-term assistance with accessing care and/or resource referrals to state, local, and community resources. This level of care if offered to MSHCN who decline ongoing Service Coordination services or a higher level of care, but need and accept short-term assistance with needs. This level of care is also offered to members not identified as MSHCN who have identified needs.

How to Contact a Service Coordinator:

Cook Children's Health Plan STAR/CHIP Service Coordination team may be reached by calling 800-964-2247 and following the prompts.

Utilization Management - Specialty Provider Referral

Cook Children's Health Plan does not require notification to the health plan of in network Provider referrals. The Primary Care Provider is responsible for coordinating referrals to network Specialty Care Providers as needed and documenting all referrals in the

Member's medical record. All out of network specialty Provider referrals require documentation of medical necessity to be submitted for prior approval of the Cook Children's Health Plan Medical Director. Member eligibility must be confirmed.

Members may self-refer for the following services:

- Obstetrics & Gynecology Services (OB/GYN)
    - Female Members may self-refer to a participating OB/GYN or GYN specialist to obtain obstetrical or gynecological related care.
    - Cook Children's Health Plan Members may also access their Primary Care Provider for these services.
- Behavioral Health Services
    - Members may access behavioral health services by contacting a network Behavioral Health Provider.
- Emergency Care
    - Members are instructed to call their Primary Care Provider as soon as possible after receiving emergency care.
    - The Primary Care Provider is not required to send notification to the Care Management Department.

Observation Stays

Observation stays are for hospital short stays of less than forty-eight hours. Prior authorization is not required.

High Risk Pregnancy Notification

Cook Children's Health Plan requests notification when Members are diagnosed with a high risk pregnancy. Providers should submit the High Risk Pregnancy Notification via our Secure Provider Portal.

Delivery Notification

All deliveries should be reported to the Care Management team. Providers should submit the Delivery Notification via our Secure Provider Portal.

Deliveries exceeding routine length of stay and/or routine DRG per the TMPPM must be reported to the Care Management Department within one business day through our Secure Provider Portal. An authorization will be required for these scenarios. Providers should submit prior authorization requests via our Secure Provider Portal.

Routine vaginal deliveries greater than three days and routine cesarean deliveries greater than five days do not require prior authorization.

Service Authorization Requests

Services requiring prior authorization must be reviewed by Cook Children's Health Plan for medical necessity prior to the provision of services to the Member. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located on our website at cookchp.org. Providers must submit prior authorization requests through our Secure Provider Portal located on our website cookchp.org.

The following categories of services require prior authorization:

- Out-of-Network Services*
- Inpatient Admissions**
- Home Health Services; Hospice
- Non-Emergency Ambulance transport
- Plastic/Reconstructive/Cosmetic Procedures
- Radiation Therapy
- Transplants
- Emergency Dental Treatment for Dental Trauma
- Services that do not require prior authorization but exceeds the TMPPM limitations, billing requirements, and/or diagnosis

*All out of network services require prior authorization except STAR Family Planning, Texas Health Steps services performed by those with valid Texas Health Steps Provider Identifier, Emergency Care and Physician services for uncomplicated deliveries, and services provided by an Indian Health Care Provider enrolled as a FQHC.

**All inpatient admissions excluding routine vaginal deliveries less than three days and routine cesarean deliveries less than five days.

Included in the prior authorization process are:

- Verification of eligibility
- Determination of medical necessity and benefits
- Referral of a Member to case or disease management programs when appropriate

Prior Authorization Determinations

Episodic (Utilization Management) Case Managers process service requests in accordance with the clinical immediacy of the requested service. If priority is not specified on the referral request, the request will default to routine status.

Severity Type	Turnaround Time
Routine	Within 3 business days after receiving the request
Urgent	Within 1 business day after receiving the request
Inpatient (Concurrent)	Within 1 business day after receiving the request
Emergent/Life Threatening	Within 1 hour after receiving the request

Prior Authorization is not a guarantee of payment

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

Prior Authorization Not Required response does not indicate that the service is a covered benefit:

A response from Cook Children's Health Plan either through the online lookup tool or when receiving a response from the health plan upon prior authorization request submission is not to be construed as a statement of benefit coverage for the requested service. Providers should review and understand Medicaid and CHIP covered benefits.

Additionally, it remains the Providers responsibility to review services per the Texas Medicaid Fee Schedule.

Inpatient Authorization and Levels of Care

Cook Children's Health Plan Episodic Case Mangers perform timely review of hospital stays and communicate authorization status to the requesting facility within contractual requirements.

Observation level of care does not require authorization.

All inpatient stays require authorization by the health plan. Facilities are expected to communicate concurrently when the authorized level does not match the facilities' billing level. Level of care appeals received after claims submission are considered payment disputes and are processed per Cook Children's Health Plan Claim policies.

Medically Necessary Services

Medically necessary means:

- For Medicaid Members birth through age twenty, the following Texas Health Steps services:
  - Screening, vision and hearing services
  - 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:
    - 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
  - May include consideration of other relevant factors, such as the criteria described in parts 2)(b-g) and 3)(b-g) of this paragraph
- For Medicaid Members over age twenty and CHIP Members, non-behavioral health-related health care services that are:
  - Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life
  - Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions
  - Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies
  - Consistent with the Member's diagnoses
  - No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
  - Not experimental or investigative
  - Not primarily for the convenience of the Member or Provider
- For Medicaid Members over age twenty and CHIP Members, behavioral health services that:
  - Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
  - Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
  - Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
  - Are the most appropriate level or supply of service that can safely be

provided
- Could not be omitted without adversely affecting the Member's mental and/ or physical health or the quality of care rendered
- Are not experimental or investigative
- Are not primarily for the convenience of the Member or Provider

Cook Children's Health Plan provides medically necessary and appropriate 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.

Medical Necessity Screening Criteria

InterQual® Criteria is utilized by Utilization Management staff to determine medical necessity and appropriateness for medical inpatient concurrent review, inpatient site of service appropriateness, home health, inpatient rehabilitation, and procedures. The Texas Medicaid Provider Procedures Manual and internally developed criteria are also used to determine medical necessity and appropriate level of care. All criteria are based upon recognized standards of care. All criteria are reviewed and approved at least annually by physicians through the Cook Children's Health Plan Medical Management and Quality Committees. Criteria utilized in the medical necessity review of a service request are available upon request by email, fax or mail.

Medical Necessity Appeals

Cook Children's Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests. Cook Children's Health Plan will send a letter that informs the Member and the service Provider of appeal rights, including how to access expedited and Independent Review Organization (IRO) appeals processes at the time a service is denied. The Member, the Member's representative, or the Member's health care Provider may appeal an adverse determination.

Medicaid Managed Care Member Complaint/Appeal Process

Member Complaint Process

Member's Right to File Complaints to Cook Children's Health Plan

A Member, or the Member's authorized representative, has the right to file a complaint either orally or in writing. Cook Children's Health Plan will resolve all complaints within thirty calendar days from the date the complaint is received.

Who can help the Member file a Complaint?

If the Member needs assistance in filing a complaint, they can contact the Member Services Department at 800-964-2247 and a Member Services Advocate will assist them.

How to file a Complaint

Members can file a complaint to Cook Children's Health Plan by calling 888-243-3312 or in writing to:

Cook Children's Health Plan
Attn: Compliance
PO Box 2488
Fort Worth, TX 76113-2488

Member's Right to File Complaints to Health and Human Services Commission

If the Member is not satisfied with the resolution of the complaint, they may also file a complaint directly with Health and Human Services Commission (HHSC). The Member must send a letter to:

Texas Health and Human Services Commission Ombudsman
Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If the Member has access to the internet, they can submit their complaint at HHS.texas.gov/managed-care-help.

How will I find out if services are denied?

Notice of Adverse Benefit Determination (Denials)

Cook Children's Health Plan must notify Members and Providers when an adverse benefit determination is issued. An adverse benefit determination includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the Cook Children's Health Plan Medical Director or the physician designee may render a denial for lack of medical necessity (adverse benefit determination).

When does the Member have the right to request an appeal?

Medicaid Member Appeal

What can I do if the health plan denies or limits the Member's request for a covered service?

When Cook Children's Health Plan denies or limits a covered service, the Member or his or her authorized representative may file an appeal within sixty days from receipt of the Notice of Adverse Benefit Determination. The Member may request that any person or entity act on his or her behalf with the Member's written consent.

Can someone from the health plan help the Member file an appeal?

A health care Provider may be an authorized representative. A representative from the Health Plan can assist the Member in understanding and using the Appeal process. If the Member needs help in filing an appeal, they can contact the Member Services Department and a Member Advocate will assist them. The Health Plan representative can also assist the Member in writing or filing an Appeal and monitoring the Health Plan Appeal through the process until the issue is resolved. Appeals are accepted orally or in writing. Within five business days of receipt of the appeal request, Cook Children's Health Plan will send a letter acknowledging receipt of the appeal request.

Continuity of Current Authorized Services

The Member may continue receiving services during the appeal if the appeal is filed within ten business days of the Notice of Action or prior to the effective date of the denial, whichever is later. The Member is advised in writing that he or she may have to pay for the services if the denial is upheld. If the appeal resolution reverses the denial, Cook Children's Health Plan will promptly authorize coverage. The Member must request to continue services during the appeal process.

Timeframes for the Appeals Process

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

Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the Member's condition or disease. Cook Children's Health Plan provides a written notice of the appeal determination to the Appellant.

Members Option to Request an External Medical Review

If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request an external medical review. The Member may request an external medical review no later than one hundred twenty days after the health plan mails the appeal decision notice.

Member Expedited Appeal

How to request an Emergency Appeal

Members or their authorized representatives may request an Expedited Appeal either orally or in writing within sixty days (or ten business days to ensure continuation of currently authorized services) from receipt of the Notice of Action or the intended effective date of the proposed Action.

Can someone from the health plan help the Member file an Emergency Appeal?

A representative from the Health Plan can assist the Member in understanding and using the emergency appeal process. If the Member needs help in filing an appeal, they can contact the Member Services Department and a Customer Care Representative will assist them. The Health Plan representative can also assist the Member in writing or filing an appeal and monitoring the health plan appeal through the process until the issue is resolved.

What happens if the health plan denies the request for an emergency appeal?

If Cook Children's Health Plan denies a request for an emergency appeal, the health plan transfers the appeal to the standard appeal process, makes a reasonable effort to give the Appellant prompt oral notice of the denial, and follows up within two calendar days with a written notice. Investigation and resolution of expedited appeals relating to an ongoing emergency or denial of a continued hospitalization are completed:

- In accordance with the medical or dental immediacy of the case and;
- Not later than one business day after receiving the Member's request for Emergency Appeal.

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

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

Members Request for State Fair Hearing

STATE FAIR HEARING INFORMATION

Can a Member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A Provider may be the Member's representative if the Provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within one hundred twenty days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within one hundred twenty days they may lose his or her right to a State Fair Hearing.

To ask for a State Fair Hearing, Member or the Member's representative should either call the health plan at 800-862-2488 or send a letter to:

Cook Children's Health Plan
Attention: Denial and Appeal Coordinator
PO Box 2488
Fort Worth, TX.76101-2488

If the Member asks for a State Fair Hearing within ten business days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services. at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within ten business days from the time the Member gets the hearing notice, the service the Health Plan denied will be stopped.

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

External Medical Review Information

Can a Member ask for an External Medical Review?

If a Member, as a Member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an external medical review. An external medical review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A Provider may be the Member's representative. The Member or the Member's representative must ask for the external medical review within one hundred twenty days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the external medical review within one hundred twenty days, the Member may lose his or her right to an external medical review. To ask for an external medical review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Cook Children's Health Plan by using the address or fax number at the top of the form.
- Call Cook Children's Health Plan at 800-964-2247.
- Email Cook Children's Health Plan at CCHPDenialandAppeal@cookchildrens.org.

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

The Member, the Member's authorized representative, or the Member's legally authorized representative (LAR) may withdraw the Member's request for an external medical review before it is assigned to an Independent Review Organization (IRO) or while the Independent Review Organization is reviewing the Member's external medical review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods:

- In writing, via United States mail, email or fax

- Or orally, by phone or in person

An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting Cook Children's Health Plan at 800-862-2247, emailing CCHPDenialandAppeal@cookchildrens.org or the HHSC Intake Team at EMR_Intake_Team@HHSC.state.tx.us.

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

Can a Member ask for an emergency External Medical Review?

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

CHIP Member Appeals

CHIP Adverse Benefit Determinations

A denial is issued when medical necessity cannot be determined for a requested service or if the requested service is determined to be experimental or investigational. Only the Cook Children's Health Plan Medical Director or physician designee can render an adverse determination. Prior to issuing an adverse determination, Providers will be notified by telephone and/or fax of the pending denial and offered the opportunity to submit additional clinical information or to discuss the Member's case with the Medical Director or physician designee. If the Member or the Member's representative disagrees with a Care Management decision, they have the right to access the Cook

Children's Health Plan Medical Necessity Appeal Process.

What can I do if the health plan denies or limits the Member's request for a covered service?

When Cook Children's Health Plan denies or limits a covered service, the Member or his or her authorized representative may file an appeal within sixty days from receipt of the Notice of Adverse Benefit Determination. The Member may request that any person or entity act on his or her behalf with the Member's written consent.

Timeframes for the Appeals Process

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

Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the Member's condition or disease. Cook Children's Health Plan provides a written notice of the appeal determination to the Appellant.

CHIP Administrative Denials

Cook Children's Health Plan may issue administrative benefit denials for the following:

- Non-covered benefit
- Insufficient information received to process the request

Failure to obtain prior authorization in a timely manner If the Member or the Member's representative disagrees with an administrative denial, they have the right to file a complaint. Additional information on filing a complaint is located in the Complaints and Appeals section of this Provider Manual.

CHIP Medical Necessity Appeals

Cook Children's Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests. Appeals are reviewed by a physician not involved in the original adverse determination. Cook Children's Health Plan informs the Member, the Provider requesting the service, and the service Provider of appeal rights, including

how to access expedited and Independent Review Organization (IRO) appeals processes at the time a service is denied. The Member, the Member's representative, or the Member's health care Provider may appeal an adverse benefit determination (medical necessity denial) orally or in writing. Within five business days from receipt of an appeal, a letter acknowledging the date that the oral or written appeal was received is sent to the appellant. Included with the letter is a list of documents/information required to process the appeal. A one page appeal form is enclosed with the acknowledgment letter when the appeal request is oral. Standard appeals resolutions are resolved and communicated to the appellant no later than thirty calendar days from receipt of the appeal.

If the Member or the Member's representative is not satisfied with the outcome of the Cook Children's Health Plan Appeal Process, they may file a complaint with:

Texas Department of Insurance
Attention: Mail Code 103-6A
PO Box 149104
Austin, TX 78714-9104
Phone: 866-554-4926

Episodic Case Management (Utilization Management) Specialty Provider Referral

Cook Children's Health Plan does not require notification to the health plan of in network Provider referrals. The Provider is asked to document all referrals in the Member's medical record. Member self-referral is not permitted. All out-of-network Specialty Provider referrals require documentation of medical necessity to be submitted for prior approval of the Cook Children's Health Plan Medical Director. Member eligibility must be confirmed.

Care Transition (Discharge Planning) and Youth to Adult

Cook Children's Health Plan Episodic Case Managers work collaboratively with facility discharge planners and Case Managers to assure a seamless transition from hospital based care to home or sub-acute care. Cook Children's Health Plan requests that facilities arrange post hospital services from in network Providers for all Member discharges. This is required for Members with Cook Children's Health Plan as primary coverage and it is requested for those with presumed secondary coverage by the Health Plan. This practice assures the best outcome should coverage change unexpectedly due to the family electing to maintain Cook Children's Health Plan coverage rather than enrolling the child in other commercial insurance or if coverage ends due to loss of job or eligibility. Using In network Providers also assists our Health Plan Members with primary commercial coverage when using their Cook Children's Health Plan coverage for balances for high cost services co-pay/deductibles and when

benefit maximums are reached. Cook Children's Health Plan has adopted the Got Transition best practice model to facilitate youth members to adult care. In network Providers are encouraged to adopt this best practice model.

Section 8: Quality Management Program

Practice Guidelines

Cook Children's Health Plan relies on the use of evidence based clinical practice and medical necessity guidelines to evaluate the quality of care, and to identify opportunities for clinical improvement. These guidelines are adapted from national guidelines for practice. All are reviewed, modified if appropriate, and approved by participating Providers and the Cook Children's Health Plan Medical Management Committee and Quality Improvement Committee, which are composed of Primary Care Providers and a variety of specialists. Clinical practice guidelines can be printed from the website at cookchp.org, or you may call 888-243-3312 to receive a printed copy.

Performance Improvement Projects

Cook Children's Health Plan is required to conduct at least two focused studies or Performance Improvement Projects (PIPS) per year based on state requirements; projects typically last two years but may extend to three years depending on the nature of the undertaking. Cook Children's Health Plan utilizes national standards, whenever possible, to measure the success of the projects. Provider participation is often a critical component to the success of these projects.

Reports on active PIPs are provided to Quality Management Committee (QMC) for quarterly review. The QMC maintains accountability and authority to review the results, issue recommendations, recommend the allocation of resources relative to PIPs, and reports these to the Cook Children's Health Plan Board of Trustees no less than annually.

PIPs are prioritized based upon the following principles:

- Relevance to the Cook Children's Health Plan business plan, mission, or vision and potential contribution to the achievement of the strategic goals of Cook Children's Health Care System.
- Relevance to high volume and/or high risk administrative and/or clinical practices.
- Potential to improve the health of enrolled populations.
- Relevance to quality of clinical care provided.
- Relevance to Provider and/or Member satisfaction
- Potential to produce measurable results.
- Relevance to state and federal regulatory agency requirements and/or nationally recognized standards.

Quality Indicators

Each year Cook Children's Health Plan evaluates the effectiveness of its Quality Improvement Program based on standards for service and quality of care established by the National Committee for Quality Assurance.

The following measures are a subset Healthcare Effectiveness Data and Information Set (HEDIS) measures of quality of health care developed by the NCQA. In addition are measures created internally to supplement HEDIS studies and are broken out in two groups, clinical and service studies.

Clinical

- Well-child visits in the first thirty months of life
- Well-child visits ages three through twenty
- Adolescent well-care visits
- Childhood Immunization Status
- Adolescent Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children With Pharyngitis
- Weight Assessment and Counseling for Nutrition and Physical Activity
- Chlamydia Screening in Women
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Follow-up Care for Children Prescribed ADHD Medication
- Prenatal and Postpartum Care
- Metabolic Monitoring for Patients on Antipsychotic Medications
- Provider Satisfaction
- Member Satisfaction
- Geographical Access Study
- Access and Availability Study
- Primary Care Access Study
- Behavioral Health Care Access Study
- Improving Medical Check-Up visits within ninety days of enrollment
- Potentially Preventable Admissions
- Potentially Preventable Readmissions
- Potentially Preventable Emergency Room Visits

Utilization Management Reporting Requirements

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

Review Process

Prospective Review

A method for reviewing and authorizing elective procedures/tests, both inpatient and outpatient, to determine if the case meets established medical quality criteria, and is being provided in the most efficient and cost-effective manner.

Concurrent Review

A method of reviewing and authorizing current ongoing medical care to ensure that the level of care is appropriate, that the care meets established quality criteria, and that the care is being delivered in the most efficient and cost effective setting.

Retrospective Review

A method of reviewing medical care provided prior to the date of review to determine if care was provided in accordance with established medical quality criteria in the most appropriate and cost effective setting.

Section 9: Complaints

Medicaid Provider Complaint Process

Provider Complaint Process to Cook Children's Health Plan

A complaint is defined as dissatisfaction expressed by a complainant with any aspect of the health plan's operation. The complaint process does not include appeals related to Medical Necessity or disenrollment decisions. A complaint does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to the satisfaction of the complainant.

Providers that wish to file a complaint about Cook Children's Health Plan or one of our Members can do so by submitting their complaint in writing. Upon receipt of the complaint the health plan will send an acknowledgement letter to the Provider within five (5) business days. Cook Children's Health Plan will fully and completely respond to all Provider complaints within thirty calendar days of receiving the complaint. Telephone communication related to the complaint will be documented in a complaint log. Email and fax documentation related to the complaint will be retained by the health plan for a period of seven years.

Providers may submit a written complaint as follows:

- Faxing a written complaint to: 682-303-0276
- Submit a written complaint by email to: CCHPComplaints@cookchildrens.org
- Submit online via our Secure Provider Portal by selecting Customer Service topic Submit a Provider Complaint
- Mail a written complaint to:

Cook Children's Health Plan
Attn: Compliance
PO Box 2488
Fort Worth, TX 76113-2488

Provider Complaint Process to Health and Human Services Commission

If the Provider is not happy with the resolution of the complaint, they have the right to file a complaint with the Health and Human Services Commission. When filing a complaint with HHSC, Providers must send a letter, the letter must explain the specific reasons you

believe Cook Children's Health Plan complaint resolution is incorrect. The complaint should include:

- All correspondence and documentation sent to Cook Children's Health Plan, including copies of supporting documentation submitted during the complaint process.
- All correspondence and documentation you received from Cook Children's Health Plan.
- All R&S reports of the claims/ services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable
- Provider internal notes and logs when pertinent.
- Memos from the state or health plan indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint.
- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes, or minutes form meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

When filing a complaint with Health and Human Services Commission, Providers must submit a letter to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320 PO Box 85200
Austin, TX 78708

CHIP Provider Complaint Process

Provider Complaint Process to Cook Children's Health Plan

For the CHIP program, Providers follow the same complaint process to Cook Children's Health Plan and Texas Department of Insurance as described below for CHIP Members.

CHIP Member Complaint

A Member or the Member's authorized representative who are not satisfied with their health care services can file a complaint with Cook Children's Health Plan. Members should call Member Services at 800-964-2247.

If a Member needs assistance with filing a complaint, a Member Services Representative can assist the Member in filing a complaint. The Member may also send the complaint in writing to Cook Children's Health Plan. Mail the complaint letter to:

Cook Children's Health Plan
Attn: Compliance

Cook Children's Health Plan will send the Member a letter within five working days telling them that the Health Plan has received their complaint. The Health Plan will also include a complaint form with the letter if the complaint was filed orally. Within thirty days of receiving the written complaint, Cook Children's Health Plan will mail the Member a letter with the outcome of the complaint. The resolution letter will include an explanation of Cook Children's Health Plan's resolution of the complaint, a statement of the specific medical and contractual reasons for the resolution; and the specialization of any physician or other Provider consulted. The resolution letter will also contain a full description of the process for an Appeal, including the deadlines for the appeals process and the deadlines for the final decision on an appeal.

Cook Children's Health Plan shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical immediacy of the case and not later than one business day after Cook Children's Health Plan receives the complaint.

If the Member does not like the response to their complaint, they can contact Cook Children's Health Plan and request an "appeal" by asking for a hearing with the complaint appeal panel. Every oral appeal received must be confirmed by a written, signed appeal by the Member or his or her representative, unless the Member asks for an expedited appeal. If a Member needs assistance with filing an appeal, a Member Services Representative can assist the Member. The complainant has the right to appear before a Complaint Appeal Panel (CAP) where they normally receive health care or at another site agreed to by the complainant. The Complaint Appeal Panel is a group of people that includes equal numbers of:

- Cook Children's Health Plan staff.
- Physicians or other Providers with experience in the area of care that is in dispute and must be independent of any physician or Provider who made the prior determination.
- Enrollees (enrollees may not be Cook Children's Health Plan staff).
- If specialty care is in dispute, the panel must include a specialist in the field of care related to the dispute.

No later than the fifth business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, Cook Children's Health Plan will provide to the complainant or the complainant's designated representative:

- Any documentation to be presented to the panel by the Cook Children's Health Plan staff

- The specialization of any physicians or Providers consulted during the investigation and
- The name and affiliation of each Cook Children's Health Plan representative on the panel

The complainant or designated representative if the enrollee is a minor or disabled is entitled to:

- Appear in person before the Complaint Appeal Panel
- Present alternative expert testimony and request the presence of and question any person responsible for making the disputed decision that resulted in the appeal

Appeals relating to ongoing emergencies or denials of continued stays for hospitalization will be completed in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after the request for appeal is received. At the request of the complainant, Cook Children's Health Plan shall provide, in lieu of a Complaint Appeal Panel, a review by a specialist of the same or similar specialty as the physician or Provider who would typically manage the medical condition, procedure or treatment and who has not previously reviewed the case. The physician or Provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide on the appeal. Initial notice of the decision may be delivered orally if followed by written notice not later than three days after the date of the decision.

The Complaint Appeal Panel only serves in an advisory role to Cook Children's Health Plan. The Health Plan will consider the findings of panel and render a final decision. The appeals process must be completed not later than thirty calendar days after receipt of the written request for appeal.

What can the Member do if Cook Children's Health Plan denies or limits a request for authorization of a covered service?

The Member may ask Cook Children's Health Plan for another review of this decision. Cook Children's Health Plan's Care Management Department can assist the Member with filing an appeal. Members can call 682-885-2252 or toll free 800-862-2247.

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

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

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that you are requesting an exception request
- The Explanation of Benefits (EOB) showing the original payment.

    - Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid & Healthcare Partnership to grant an authorization for the exact items that were approved by the plan
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.
    - If sending the demand letter, it must identify the client name, identification number, date of service (DOS), and recoupment amount.
    - The information should match the payment EOB.
- Completed clean claim.
    - All paper claims must include both a valid NPI and TPI numbers.
    - Note: In cases where issuance of a prior authorization is needed, the Provider will be contacted with the authorization number and the Provider will need to submit a corrected claim that contains the valid authorization number.
    - Mail appeal request:

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

CHIP Provider Appeal Process to Texas Department of Insurance

Upon receipt of the appeal outcome, if a Provider is dissatisfied, the Provider may contact TDI for further resolution. For more information:

Call: 800-252-3439
Fax: 512-475-1771
Mail: Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

CHIP Member or Provider Filing Complaints with TDI

If the a CHIP Member or Provider is not satisfied with the outcome of the Cook Children's Health Plan Appeal Process, they can file a complaint with the Texas Department of Insurance. The Member and Provider can call the Texas Department of Insurance toll free at 800-252-3439 or in writing to:

Texas Department of Insurance
Attention: Mail Code 103-6A
PO Box 149091
Austin, TX 78714-9091
Phone: 800-252-3439

No Retaliation

Cook Children's Health Plan will not punish a child or other person for:

- Filing a complaint against Cook Children's Health Plan or
- Appealing a decision made by Cook Children's Health Plan

Cook Children's Health Plan is required to comply with the complaint and appeal procedures as defined by the Texas Department of Insurance.

Section 10: Behavioral Health Services

Cook Children's Health Plan manages the delivery of mental health and substance use disorder services for covered Medicaid Members, CHIP Members and CHIP Perinate Newborn Members.

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

Improved health outcomes can be achieved by providing Members with access to a full continuum of mental health and substance use services through our network of contracted Behavioral Health Providers.

Definition of Behavioral Health

Behavioral Health is defined as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Behavioral Health Scope of Services

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

Cook Children's Health Plan will work with participating Behavioral Health Provider, Primary Care Providers, medical/surgical specialists, organizational Providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health.

These programs may include:

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

- Depression screening in adults

Primary Care Provider Requirements for Behavioral Health

Primary Care Providers may provide behavioral health services within the scope of their practice. Primary Care Providers are responsible for coordinating the Member‘s physical and behavioral healthcare, including making referrals to Behavioral Health Providers when necessary. Primary Care Providers should submit claims to Cook Children’s Health Plan for consideration

Primary Care Providers are responsible for identifying and referring any member three years or older suspected of having a developmental delay or developmental disability, severe emotional disturbance (SED), mental illness or chemical dependency.

Primary Care Providers are required to utilize valid screening and assessment instruments to identify and refer children to providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has SED or another type of mental illness

Valid screening and assessments are located at cookchp.org

If applicable Primary Care Providers will refer the Member or young adult to a Provider specializing in evaluations to determine whether the child or young has a developmental disability or is at risk for or has a serious emotional disturbance or mental illness

Primary Care Provider Referral

Cook Children’s Health Plan Members can self-refer to any in network Behavioral Health Provider for initial evaluation for behavioral health treatment. All behavioral health services which require prior authorization must be coordinated through Cook Children’s Health Plan.

Prior Authorization

Prior authorization may be required prior to seeing a Behavioral Health Provider. Services requiring prior authorization must be reviewed by Cook Children’s Health Plan for medical necessity prior to the provision of services to the Member. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located on our website at cookchp.org. Providers must submit prior authorization requests through our Secure Provider Portal located on our website cookchp.org.

Availability and Access

Cook Children's Health Plan Members may self-refer to any network Behavioral Health Provider. Each network Provider shall provide covered services during normal business hours. Covered services shall be available and accessible to Members, including telephone access, on a twenty-four hour, seven day per week basis, to advise Members requiring urgent or emergency services.

The following are acceptable phone arrangements for contacting physicians after normal business hours:

- Office phone is answered after hours by an answering service.
    - All calls answered by an answering service must be returned within thirty minutes.
- Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the patient to call another number to reach another Provider designated to you.
    - Someone must be available to answer the designated Provider's phone. Another recording is not acceptable.
- Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact another designated medical practitioner.
- Members who "no-show" for an appointment are contacted within twenty-four hours in an attempt to reschedule them.

Emergency Services

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows:

Covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

Members should be directed to call 911 or seek care from the nearest emergency facility when an emergency behavioral health condition exists.

Emergency Screening and Evaluation Plan

Members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, or by an emergency service

program. This process allows Members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the emergency evaluation is completed, the facility or program clinician should request prior authorization from Cook Children's Health Plan. Providers may request prior authorization via the secure provider portal. Clinical documentation should be provided with the request.

The facility/program clinician is responsible for locating a bed, but may request Cook Children's Health Plans assistance. The facility/ program may contact an Out-of-Network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in network or Out-of-Network psychiatric facility available, Cook Children's Health Plan will authorize boarding the Member on a medical unit until an appropriate placement becomes available.

Accessible Intervention and Treatment

Cook Children's Health Plan promotes early intervention and health screening for identification of behavioral health problems and patient education. Providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate) any behavioral health problem. Primary Care Providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using the DSM codes
- Inform Members how and where to obtain behavioral health services
- Understand that Members may self-refer to any Behavioral Health Provider without a referral from the Member's Primary Care Provider

Providers who need to refer Members for further behavioral health care and need assistance should contact Cook Children's Health Plan. Cook Children's Health Plan continuously evaluates Providers who offer services to monitor ongoing behavioral health conditions, such as regular lab or ancillary medical tests and procedures.

Medicaid and CHIP Covered Services

Behavioral Health Services that are offered to Medicaid and CHIP Members are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder.
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.

- Furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- The most appropriate level or supply of service that can safely be provided;
- Could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered.
- Not experimental or investigative, and not primarily for the convenience of the Member or Provider.

Other elements of Members receiving Behavioral Health Services are:

- Member may self-refer to any network Behavioral Health Provider.
- Member has the right to obtain medication from any network pharmacy.
- Primary Care Provider may refer a Member to a Behavioral Health Provider.
- Coordination between behavioral health and physical health services.
- Member has the right to obtain a second opinion; medical records and referral information must be documented using the most current edition of DSM classifications.
- Authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient or guardian prior to receiving care from a Behavioral Health Provider.
- Members under the age of twenty-one will be provided inpatient psychiatric services, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction.
- Coordination will be conducted with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for Members committed by a court of law to the state psychiatric facility.
- Assessment documents for behavioral health will be made available for the use of Primary Care Providers.
- Cook Children's Health Plan will work to ensure that quality behavioral health services are provided to all Members.

This coordination will include focus studies and utilization management reporting Providers will have procedures for follow up on missed appointments. The procedures will include contact with the Member within twenty-four hours of a missed appointment for the purposes of rescheduling.

- Members who are discharged from an inpatient psychiatric facility will have a follow up appointment within seven days from the date of discharge by the Provider.

Medicaid Covered Services

The following is a non-exhaustive, high level listing of acute care covered services included under the Medicaid Program. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, Providers should refer to the current Texas Medicaid Provider Procedures Manual at tmhp.com. These services are subject to modification based on federal and state mandates.

A Primary Care Provider referral is not required to access Behavioral Health Services.

Medicaid covered Behavioral Health Services include, but are not limited to, medically necessary:

- Inpatient mental health services for children
- Acute inpatient mental health services for adults
- Outpatient mental health services for children and adults
    - 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 in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1,§412.303(48). QMHP-CSs shall be Providers working through a DSHS- contracted Local Mental Health Authority or a separate DSHS- contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services
    - Does not require Primary Care Provider referral
- Psychiatry Services
- Counseling Services for adults (twenty-one years of age and over)
- Outpatient Substance Use Disorder Treatment Services, including:
    - Assessment
    - Detoxification Services
    - Counseling Treatment
    - Medication-Assisted Therapy
- Residential Substance Use Disorder Treatment Services including:
    - Detoxification Services
    - Substance Use Disorder Treatment (including room and board)

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 Cook Children's Health Plan's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

- Emergency Services.
- Hospital Services, including inpatient and outpatient.
    - Cook Children's Health Plan may provide inpatient Sservices for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute inpatient hospital setting.
    - Cook Children's Health Plan may provide Substance Use Disorder Treatment Services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.

CHIP Covered Services

The following is a non-exhaustive, high level listing of acute care covered services included under the CHIP Program. These services are subject to modification based on federal and state mandates.

A Primary Care Provider referral is not required to access behavioral health services.

CHIP covered Behavioral Health Services include, but are not limited to, medically necessary:

- Inpatient Mental Health Services: Including serious emotional disturbance (SED), furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:
    - Neuropsychological and psychological testing
    - When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination
    - Does not require Primary Care Provider referral
- Outpatient Mental Health Services: Including serious emotional disturbance (SED) for serious mental illness, provided on an outpatient basis, including, but not limited to:
    - The visits can be furnished in a variety of community-based settings

(including school and home-based) or in a state-operated facility
    - Neuropsychological and psychological testing
    - Medication Management
    - Rehabilitative Day Treatments
    - Residential Treatment Services
    - Sub-Acute Outpatient Services (partial hospitalization or rehabilitation day treatment)
    - Skills training (psycho-educational skill development)
    - When Outpatient Psychiatric Services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination
    - A Qualified Mental Health Provider – Community Services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be Providers working through a DSHS- contracted Local Mental Health Authority or a separate DSHS- contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services
    - Does not require Primary Care Provider referral
- Inpatient Substance Use Disorder Treatment Services: Include, but are not limited to:
    - Inpatient and Residential Substance Use Disorder Treatment Services, including detoxification and crisis stabilization, and twenty-four hour residential rehabilitation programs
    - Does not require Primary Care Provider referral
- Outpatient Substance Use Disorder Treatment Services: Include, but are not limited to the following:
    - Prevention and Intervention Services that are provided by a physician and non-physician Providers, such as screening, assessment and referral for chemical dependency disorders
    - Intensive Outpatient Services
    - Partial hospitalization
    - Intensive Outpatient Services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life-skills training that consists of at least ten hours per week for four to twelve weeks, but less than twenty-four hours per day
    - Outpatient Treatment Services is defined as consisting of at least one to two

hours per week providing structured group and individual therapy, educational services, and life skills training
- Does not require Primary Care Provider referral

Note: These services are not covered for CHIP Perinates (Unborn Children).

Outpatient Benefits

Outpatient Behavioral Health Treatment is an essential component of a comprehensive health care delivery system. Cook Children's Health Plan Members may access outpatient mental health and substance use services by self-referring to a network Provider, by calling Cook Children's Health Plan, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their Primary Care Provider; however, a Primary Care Provider referral is never required for Behavioral Health Services.

Inpatient Benefits

Cook Children's Health Plan is responsible for authorizing inpatient hospital services, which includes services provided in freestanding psychiatric facilities for Medicaid and CHIP Members.

Members Discharged from Inpatient Psychiatric Facilities

Cook Children's Health Plan requires that all Members receiving Inpatient Psychiatric Services must be scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. The Provider must follow up with the Member and attempt to reschedule missed appointments. Behavioral Health Service Providers must contact Members who have missed appointments within 24 hours to reschedule appointments.

Transitioning Members from One Behavioral Health Provider to Another

If a Member transfers from one Behavioral Health Provider to another, the transferring Provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from Behavioral Health Provider to Primary Care Provider), to the receiving Provider.

Attention Deficit Hyperactivity Disorder

Treatment of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), including follow-up care for children prescribed ADHD medication, is covered as outpatient mental health services. Cook Children's Health Plan will reimburse Providers for the treatment of ADHD in children who are eligible Members as well as for any follow-up visits

with children for whom they have prescribed medications to treat ADHD.

Cook Children's Health Plan requests that the Primary Care Providers or another provider with prescriptive authority complete a visit with a Member prescribed ADHD medications within thirty days of starting the medication to evaluate efficacy and assess adverse side effects before prescribing further medication. Additionally, children and adolescents on ADHD medication should have at least two follow-up visits in the nine months following the initial thirty day visit.

Non-Covered Behavioral Health Services

Members may access local community resources for Behavioral Health Services that are not covered. Services may be sought through the local office of the Texas Department of State Health Services or located through the Texas 211 website at 211texas.org.

Members may also receive services through the Local Mental Health Authority (LMHA). The LMHA accepts patients with chronic mental health disorders (i.e. schizophrenia, bi-polar disorder, severe major depression). In the event that a Cook Children's Health Plan Member will need to access services through the local mental health authority, the health plan staff will assist the Member through the LMHA system of care.

Coordination of Care

Behavioral Health service Providers are expected to communicate at least quarterly and more frequently, if necessary, regarding the care provided to each Member with other behavioral health service Providers and Primary Care Providers. Behavioral health service Providers are required to refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Provider for examination and treatment.

Copies of prior authorization forms, referral forms and other relevant communication between Providers should be maintained in both Providers' files for the Member. Coordination of care is vital to ensuring Members receive appropriate and timely care.

Coordination between Physical and Behavioral Health

Cook Children's Health Plan is committed to coordinating medical and behavioral care for Members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities. Cook Children's Health Plan will designate behavioral health Service Coordination, Care Coordination or Case Management personnel to facilitate coordination of care and case management efforts.

Coordination with the Local Mental Health Authority

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

Court-Ordered Commitments

A "Court-Ordered Commitment" means a confinement of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Cook Children's Health Plan is required to provide inpatient psychiatric services as a condition of probation to Members under the age of twenty-one (21), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities.

Cook Children's Health Plan will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for Members under age twenty-one. Any modification or termination of services will be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under the provisions of the Texas Health and Safety Code cannot appeal the commitment through Cook Children's Health Plan's complaint or appeals process.

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

Member consent for Disclosure of Information

The Primary Care Provider is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the Behavioral Health Provider and the Member's Primary Care Provider. If the Member refuses to release the information, they will sign the consent for disclosure of information that indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. An authorization for Behavioral Health and Primary Care Provider to Share Confidential Information form is located at cookchp.org.

Treatment Record Reviews

Cook Children's Health Plan reviews Member records and uses data generated to monitor and measure Provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, and Attention Deficit Hyperactivity Disorder (ADHD)
- Continuity and coordination with Primary Care Providers and other treatment Providers
- Explanation of Member rights and responsibilities
- Inclusion of all applicable required medical record elements as listed below
- Allergies and adverse reactions; medications; physical exam

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

Treatment Record Standards

Cook Children's Health Plan reviews Member records and uses data generated to monitor and measure Provider performance in relation to the treatment record standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, and Attention Deficit Hyperactivity Disorder.
- Continuity and coordination with primary care Providers and other treatment Providers.
- Explanation of Member rights and responsibilities.
- Inclusion of all applicable required medical record elements as listed below.
- Allergies and adverse reactions; medications; physical exam.

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

Screening for Depression

Documentation in the medical record is required demonstrating the use of a nationally

recognized standardized screening instrument AND the outcome of the screen.

Although it is expected the instrument will be used most frequently in Primary Care, it is accepted if the standardized instrument is used in another clinic. Approved screening instruments include:

- PRIME-MD (2 question screen used by Whooley & Colleagues)
- MOS Depression items (recommended for patients under age sixty)
- CEB-D (Five item brief version developed as screening instrument for patients age sixty and over)
- SSDS-PC
- PHQ-2 & PHQ-9
- CESD (Five, ten, twenty item version)
- BDI-S (Thirteen item version)
- BDI (Twenty-one items)
- Hamilton Rating Scale for Depression
- DSM criteria for MDD
- Williams et al one-item screener

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

Definition of severe and persistent mental illness (SPMI):

- Mental illness with complex symptoms that require ongoing treatment and management, most often consisting of varying types and dosages of medication and therapy

Definition of severe emotional disturbance (SED):

- A serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder that severely disrupts a child's or adolescent's ability to function socially, academically, and emotionally, at home, in school, or in the community, and has been apparent for more than a six month period

Member Access to and Benefits of MHR and TCM

Mental Health Rehabilitative Services and Mental Health Targeted Case Management are available to Medicaid recipients who are assessed and determined to have:

- A severe and persistent mental illness such as schizophrenia, major depression,

bipolar disorder or other severely disabling mental disorder.

- Children and adolescents ages three through seventeen years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance.

Targeted Case Management

- Must be face to face.
- Include regular, but at least annual, monitoring of service effectiveness.
- Proactive crisis planning and management for individuals.

Provider Requirements

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA) can be found at Adult Needs & Strengths Assessment.
- Training and certification to administer Child and Adolescent Needs and Strengths (CANS) can be found at Child & Adolescent Needs & Strengths Assessment.
- Providers must follow current Resiliency and Recovery Utilization Management Guidelines (RRUMG) found at Utilization Management Guidelines & Manual.
- Attestation from Provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG.
- Provider must review a members plan for Mental Health Rehabilitative Services to determine conditions or needs warrants a reassessment or change in service.
- HHSC-established qualification and supervisory protocol, this criteria is located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

Providers must also complete the Targeted Case Management and Rehabilitative Services Request Form located at cookchp.org and submit them to Cook Children's Health Plan. All authorizations and claims processing must be submitted to Cook Children's Health Plan via the Secure Provider Portal.

Focus Studies and Utilization

Cook Children's Health Plan, has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to health plan Members.

Cook Children's Health Plan routinely monitors inpatient and outpatient data, including claims, medical records, and supplemental data, to improve both behavioral health outcomes and physical health outcomes resulting from behavioral health integration into

the Member’s overall care.

Cook Children’s Health Plan also routinely monitors claims, encounters, referrals and other data for patterns of potential over and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

Behavioral Health Quality Improvement Studies

Formal quality improvement studies for behavioral health are designed with input from a multi-disciplinary team/committee to ensure valid findings. Data is collected from an administrative database, medical record reviews, surveys and office site visits. Clinical and preventive service studies will in most instances be based on measurement against clinical guidelines.

In addition, both clinical and service indicators will be trended and reported. Performance Improvement Projects such as HEDIS follow-up after hospitalization for mental illness will be conducted on an annual basis. The findings from these reviews will be communicated to Providers, as applicable. Questions may be directed to Cook Children's Health Plan Quality Management Department toll free at 888-243-3312.

Programmatic success is dependent upon the development of a strong neighborhood Provider, hospital and ancillary Provider network that actively interacts with Behavioral Health Providers to meet the needs of the Cook Children's Health Plan Members. Through both formal and informal interaction with Providers on the results of studies, Provider data sharing, availability of resource information and timely feedback on areas for improvement, Cook Children's Health Plan will provide support in delivering the highest quality of care and service to Members. Cook Children's monitors Member satisfaction surveys, complaints, grievances, and feedback from the Community/Member Advisory Committee. Cook Children's Health Plan has the opportunity to meet and exceed the needs of the communities that it serves.

Notifying Cook Children's Health Plan of Reportable Events

Reportable events (also known as Critical Incidents) are incidents or outcomes involving Cook Children's Health Plan Members seeking or receiving services from in network Providers that may require further analysis. They also include events that occur during a Member's transition to home or an alternative level of care. Tracking of reportable events is a contractual requirement for our Providers, so it is important to report an occurrence promptly.

Notification to the health plan that a reportable event has taken place must be documented on the Cook Children's Health Plan Reportable Event Form, located on our website cookchp.org and sent to the Quality Improvement Department via email to CCHPQualityImprovement@cookchildrens.org or by fax to 682-885-8494 as soon as reasonably possible, but ideally within one business day of the date you became aware of the event. Written supplemental notes or a copy of clinical records may be requested.

Reportable Events include but are not limited to the following events occurring within any treatment setting:

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Suicide attempt	Attempted suicide while inpatient (or at any Provider site) or if needed emergent care and last discharge was within 7 days	Attempted suicide at any other level of care than inpatient with no apparent Provider culpability
Completed or attempted homicide	Completed homicide while in any level of treatment	Attempted homicide in any level of care with no apparent Provider culpability
Death by any cause	Death by suicide at any level of care, death by any cause while inpatient for psychiatric/substance use treatment, or death by an unknown cause while in any other level of care Death of any consumer while at a provider site (regardless of whether or not the consumer is a Cook Children's Health Plan Member)	Death by any cause while in any other level of care
Allegations of sexual or physical abuse/neglect/exploitation	Allegations of sexual or physical abuse/neglect/exploitation by a Provider or non-consensual sex between consumers while at a Provider site or where services are rendered Rape, abuse, or assault by staff that is considered founded (witnessed by staff or other consumers, involving an admission by	Allegations of sexual or physical abuse/ neglect/exploitation by non-Provider (occurring at a Provider site or within the Member's home) and consensual sex between consumers at a Provider site or where services are rendered

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
	the perpetrator, involving clinical evidence, etc.) regardless of whether or not a Cook Children's Health Plan Member was involved or present	
Assault within a facility or Provider site	Assaults while in a facility that require serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit)	Assaults while in a facility that require minor or no medical treatment (such as first aid, assessment/monitoring by on-site medical staff)
Absent without leave for longer than two (2) hours	Absent without leave from residential Provider for longer than two (2) hours and at risk to self or others	Absent without leave from a residential Provider for longer than two (2) hours with no apparent serious risk and did not return with any contraband, illicit substances, etc. This does not include adults leaving voluntary residential treatment if they have been assessed to not be at risk to self or others.
Undesirable events inconsistent with routine patient care	Undesirable events inconsistent with routine patient care of a serious nature (adverse medical complications, inebriation, etc.)	Undesirable events inconsistent with routine patient care of a moderate nature
Breach of confidentiality	Breach of Confidentiality	

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Parent/guardian taking child AMA from residential setting with child at risk Adult leaving treatment voluntarily while at serious risk	Parents or guardian taking child AMA from any inpatient setting with child at risk due to AMA (kidnapping, etc.) or adult leaving treatment voluntarily while at serious risk for incarceration or hospitalization (such as demonstrating suicidal ideation or unstable mental or physical health status)	
Accidental injuries at a Provider site requiring medical treatment more than first aid	Serious accidental injuries either in a facility or a Provider site (wherever services are rendered) requiring urgent/emergent life-saving care or skilled nursing (such as Emergency Department or Urgent Care visit)	Non-serious accidental injuries either in a facility or at a Provider site (wherever services are rendered) requiring medical treatment more than first aid (First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages)
Medication/treatment errors	Medication /treatment errors causing severe or potentially severe harm or distress to the Member	Medication/treatment errors not resulting in severe or potentially severe harm or distress to the Member
Adverse reactions to medication/treatment	Adverse reactions to medication/treatment causing severe or potentially severe harm or distress to Member (NMS, etc.)	Adverse reactions to medication/treatment of a moderate or minor nature

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Fire setting or property damage Emergency services summoned to facility other than false alarm	Any time emergency services (fire department, police, EMS, etc.) are summoned to a facility for any reason, such as fire setting, property damage, commitment of a crime, etc.	Fire setting or property damage that does not result in summoning emergency services but does require immediate action or repairs to ensure member safety. False alarms are not reportable.
Temporary closure of facility	Any condition that results in temporary closure of a facility, regardless of whether or not a Cook Children's Health Plan Member is affected by the closure.	
Possession of deadly weapon with the *threat of use by Member* at Provider site	Possession of a deadly weapon and the threat of use of the weapon by member while in any facility, at a Provider site, or wherever services are rendered	
Outbreak of serious communicable disease	Outbreak of a serious communicable disease, regardless of whether or not a Cook Children's Health Plan Member is present at the time of the notification.	
Other Member safety concern	Other	Other
Any real or threatened litigation in a case against a Provider or Cook Children's Health Plan	ANY real or threatened litigation in a case against Cook Children's Health Plan or a Provider involving a Cook Children's Health Plan Member/family	Any real or threatened litigation against a Provider not involving a Cook Children's Health Plan Member/family
Administrative discharge		Administrative Discharge

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Restraint	Restraint while in a facility or at a Provider site (or wherever services are rendered) that requires serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit) OR restraint that is unauthorized/used improperly/applied incorrectly. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized.	Restraint while in a facility that requires minor or no medical treatment (such as first aid, assessment/monitoring by on-site medical staff)
Self-injuries behavior	Self-Injurious Behavior that occurs at a Provider site (or wherever services are rendered) and is potentially life threatening or requires serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit)	Self-Injurious Behavior that occurs at a Provider site (or wherever services are rendered) requiring medical treatment more than first aid (First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages) Or, Self-Injurious Behavior that demonstrates a new behavioral pattern of concern
Media contact	An occurrence that involves contact with the media: presence or inquiry by newspaper, news	

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
	station, media outlet, etc. with the possibility that a public communication will be distributed.	

If you are in doubt that a critical incident has occurred, please notify the Quality Improvement Department so that the information can be reviewed.

Section 11: Appendix

1. CHIP Cost Sharing Grid
2. CHIP ID Card
3. CHIP Perinate ID Card
4. STAR ID Card
5. Member Acknowledgement Statement
6. Private Pay Agreement
7. Specialist Acting as a PCP Request Form

CHIP Cost-Sharing	
	Effective July 1, 2022
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL* or otherwise exempt from cost-sharing.	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$25

CHIP Cost-Sharing	
	Effective July 1, 2022
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$125
Cost-sharing Cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
**Per 12-month term of coverage.
***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

Your Cook Children's Health Plan ID card

When and where do I use my Cook Children's Health Plan ID card?

Everyone who becomes a member of our health plan gets an ID card. This ID card has important phone numbers that you may need. The ID card gives the doctor and office staff important information.

If you get an ID card that does not have the correct Primary Care Provider or if it has wrong information listed, call Member Services at **1-800-964-2247**. They will help you get a new ID card.

How to use your/your child's ID card

Take your Cook Children's Health Plan ID card with you at all times and show it to the provider, clinic or hospital to get the care you need. They will need the details on the card to know that you are a Cook Children's Health Plan member. Do not let anyone else use your ID card.

You will not get a new ID card every month. If you call us to change your Primary Care Provider or if your copay changes, we will send a new ID card. We will also send you a new ID card if you request one.

How to read your/your child's Cook Children's Health Plan ID card

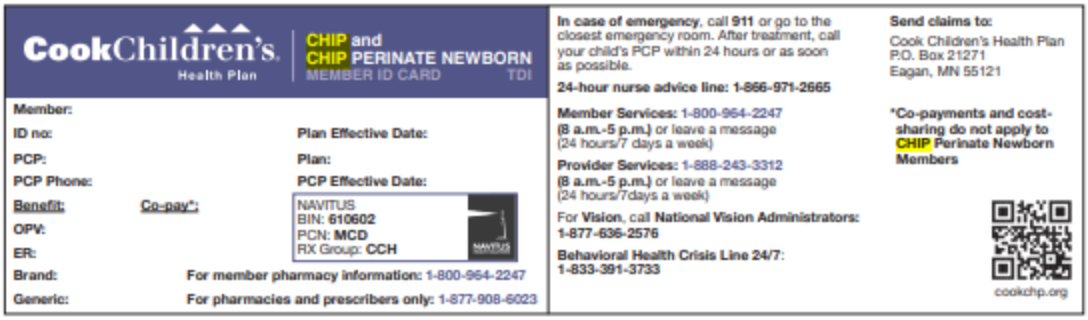
Your ID card will say CHIP and identify you as a Cook Children's Health Plan member. Your ID card is in English and Spanish, and has the following information on it:

- Member's name
- Member's ID number
- Primary Care Provider's name and phone number
- Co-payment information (if you have to pay for services)
- Member Services phone number
- Behavioral Health Crisis Line 24/7
- National Vision Administrators phone number
- Nurse Advice Line 24/7 phone number

How to replace a lost or stolen ID card?

If you lose your ID card or if it is stolen, call Member Services at **1-800-964-2247**. They will send you a new ID card.

Here is what a Cook Children's Health Plan ID card looks like:



Your Cook Children's Health Plan ID card

When and where do I use my Cook Children's Health Plan ID card?

Everyone who becomes a member of our health plan gets an ID card. This ID card has important phone numbers that you may need. The ID card gives the doctor and office staff important information.

If you get an ID card that does not have the correct Primary Care Provider (PCP) or if it has wrong information listed, call Member Services at **1-800-964-2247**. They will help you get a new ID card.

How to use your ID card

Keep your Cook Children's Health Plan ID card with you at all times and show it to the provider, clinic or hospital to get the care you need. They will need the details on the card to know that you are a Cook Children's Health Plan Member. Do not let anyone else use your ID card.

You will not get a new ID card every month. If you call us to change your Primary Care Provider, we will send a new ID card.

How to read your Cook Children's Health Plan ID card

Your ID card will say STAR and will have Cook Children's Health Plan on it.

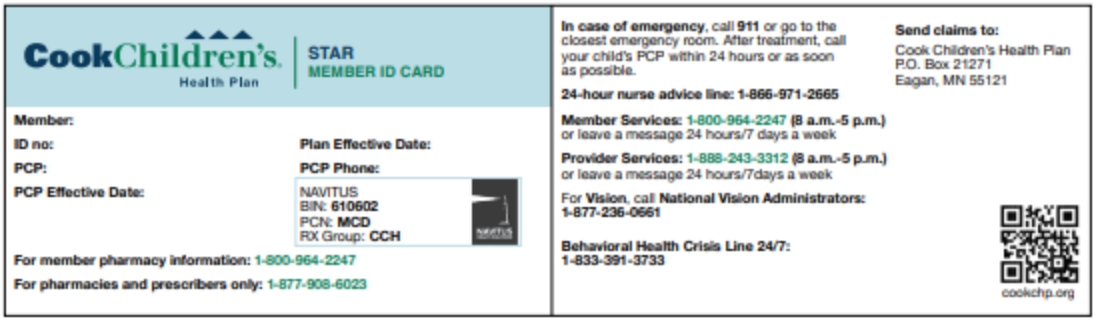
Your Cook Children's Health Plan ID card is in English and Spanish, and has the following information on it:

- Member's name
- Member's ID number
- Primary care provider's name and number
- Member Services phone number
- Behavioral Health Crisis Line 24/7
- Vision services phone number
- Nurse Advice Line 24/7 phone number

How to replace a lost or stolen ID card?

If you lose your ID card or it is stolen, call Member Services at **1-800-964-2247**. They will send you a new ID card.

Here is what a Cook Children's Health Plan ID card looks like:



Member Acknowledgment Statement

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

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

Member Signature Date

Private Pay Agreement

I understand that _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any services that I receive. The provider will not file a claim to Medicaid for the services that are provided to me.

Signed: _____

Date: _____

Cook Children's Health Plan

Specialist Acting as a Primary Care Provider Request Form

Please complete the Specialist Acting as a Primary Care Provider Request Form and return to Care Management
Fax: 682-885-8402 or toll free 844-643-8402
Phone: 888-243-3312

Provider Information

Provider Name: _____

Primary Specialty: _____ Secondary Specialty: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Tax ID Number: _____ NPI Number: _____ TPI Number: _____

Contact Name: _____ Title: _____

Contact Phone Number: _____ Contact Fax Number: _____

Contact Email Address: _____

Member Information

Member Name: _____

Member ID Number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone Number: _____

Parent/Legal Guardian: _____

Explain medical indication for Specialist acting as a Primary Care Provider for this patient:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Completed by Date

CookChildren's Health Plan

Tarrant Service Area

Denton, Hood, Johnson, Parker, Tarrant, Wise

June 2023

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