# Primary Care Provider Orientation

Revised: 060722

Cook Children's Health Plan

# Our Promise

Knowing that every child's life is sacred, it is the Promise of Cook Children's to improve the health of every child through the prevention and treatment of illness, disease and injury.

Cook Children's Health Plan

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# Provider Support Services

**888-243-3312**

A representative is available Monday – Friday, 8am-5pm, excluding State holidays.

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# Benefits, Limitations and Exclusions

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.

When submitting services for reimbursement Providers should refer to the most recent publications of the:

- Texas Medicaid Provider Procedures Manual located at tmhp.com
- 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

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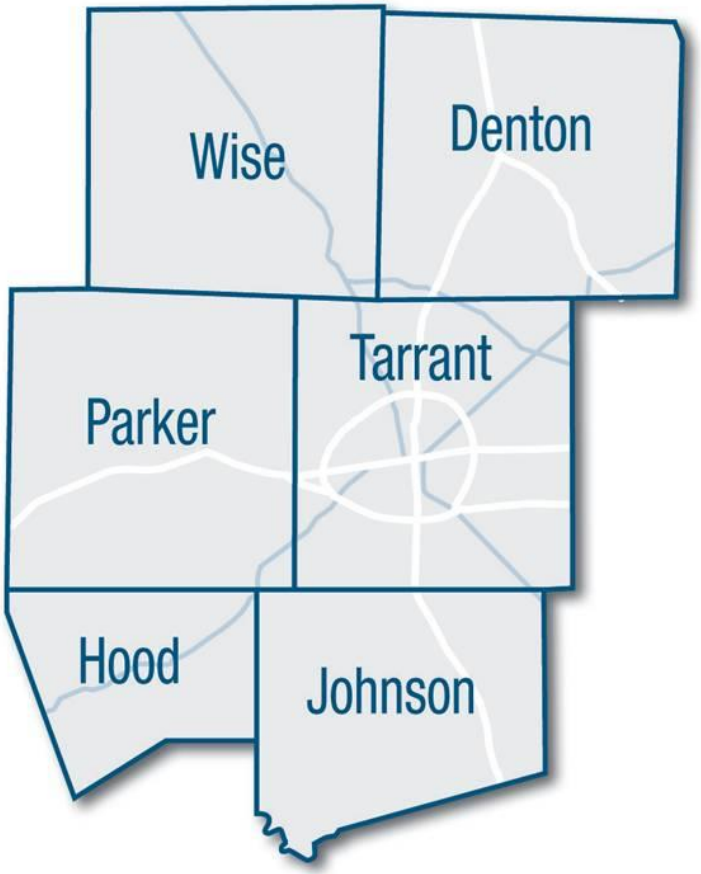
# Service Delivery Area

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# Re-Credentialing, Termination, and Provider Demographic Changes

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# Provider Updates

For in depth information on the Joining the Network, Re-credentialing, Termination and Provider Demographic updates visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Credentialing, Re-Credentialing, Termination and Provider Demographic Changes.

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# Network Development Information

Mail: Cook Children's Health Plan
Attn: Network Development
P.O. Box 2488
Fort Worth, TX 76113

Phone: 888-243-3312
Email: CCHPNetworkDevelopment@cookchildrens.org
Fax: 682-885-8403

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# Member Dismissal

# Member Dismissal from Provider

Providers may request that a Member be removed from their panel when efforts to counsel the Member have been unsuccessful regarding one of the following:

- Appointment compliance
- Cooperation with Provider treatment plan
- Inappropriate/disruptive behavior toward Provider, staff, other patients

The request to remove a Member from a Provider panel must be submitted in writing to the Member and the health plan.

- Notify the Member that they must select a new Provider within thirty (30) days of the notice
- The Provider must provide thirty (30) days emergency care during the notice period

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# Member Dismissal Notification

Providers may send the notification to the health plan by mail or via the Secure Provider Portal.

Mail: Cook Children's Health Plan
Attention: Member Services
P.O. Box 2488
Fort Worth, TX 76113

Online: Secure Provider Portal

- Submit a Customer Service Request
  - Topic: Request for Patient/Member Reassignment

# Provider Responsibilities

# Medical Homes

Primary Care Providers serve as a medical home to Members.

General Provider Responsibilities also include:

- Access & Availability
- Provider Demographic Updates
- Verification of Member eligibility
- Submitting prior authorizations for service
- Medical Records retention and availability
  - The medical records must reflect all aspects of Member care, including ancillary services
  - The use of electronic medical records must conform to the HIPAA requirements and other federal and state laws

# Out of Area Providers

Must have a local or toll free number to be included in the Provider Directory.

# Access and Availability

Managed Care Organizations are contractually and financially responsible for meeting Health and Human Services (HHS) access standards.

Health plans are required to verify that covered services furnished by network Providers are available and accessible to Members.

For this reason Cook Children's Health Plan conducts an Access and Availability survey of all Provider types once every fiscal year.

Access to Primary Care Providers, Specialty Care Providers, Ancillary Providers and Network Facility Providers must be available to Members for routine, urgent and emergent care.

- It is important to keep the health plan updated with changes to your on-call Providers
- Providers must provide a response to a Member's after-hours call within thirty (30) minutes

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# Access and Availability

During regular office hours, Providers should make every effort to:

- Answer the telephone within five (5) rings or thirty (30) seconds
- Respond to non-urgent voicemails within four (4) hours
- Not exceed a hold time of three to five (3-5) minutes without giving the patient the opportunity to continue to hold or leave a message

Please adhere to the regulatory standards listed:

| LEVEL/TYPE OF CARE | TIME TO TREATMENT (CALENDAR DAYS) |
|---|---|
| **Treatment of an urgent condition, including urgent specialty care** | Provided within 24 hours |
| **Specialty Physician Referral (based upon urgency)** | Provided within 5 days |
| **Primary Routine Care** | Provided within 14 days |
| **Preventive Health Services for Adults 21 and older** | Offered within 90 days |
| **Preventive Health Services for newborn Members (less than 6 months)** | Offered within 14 days |
| **Preventive Health Services for child Members (6 months to age 20)** | Offered within 60 days |

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# Electronic Services – EFT & ERA

Providers must elect to receive Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) for all Cook Children's Health Plan claim payments.

Detailed enrollment information can be found on the Provider Relations page as well as the Electronic Submission Services page located on our website at cookchp.org.

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# Referrals Requiring Prior Authorization

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

If you would like additional information regarding referrals please see the Provider Manuals on our website, cookchp.org.

All out of network referrals must receive prior authorization from the health plan before the out of network service can occur.

All prior authorization requests must be submitted via the Secure Provider Portal.

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# Caring for Newborns

Primary Care Providers who provide covered services for Medicaid (STAR) and CHIP newborns must:

- Have admitting privileges at a hospital that is part of the Cook Children's Health Plan network or able to make referral arrangements with an in network Provider who has admitting privileges to a network hospital

# Provider Marketing Guidelines

Marketing, as defined by HHS, is any communication from a Provider to a Medicaid Member or Cook Children's Health Plan Member that can reasonably be interpreted to influence the Member's choice of Provider.

- A Provider participating in Medicaid may engage in Provider marketing as long as the Provider marketing does not involve unsolicited personal contact or promotion of the Provider's practice that is not intended for health education purposes
- Providers must adhere to all of the marketing guidelines
- Providers are encouraged to read the Texas Provider Marketing Guidelines carefully before marketing their services

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# Provider Marketing Guidelines

- The guidelines can be accessed from the Texas Medicaid & Healthcare Partnership's (TMHP) at www.tmhp.com/pages/topics/marketing.aspx
  - There you will find links to related news articles as well as helpful tips, specific guidelines, examples of permissible and prohibited marketing activities, a self-review checklist and associated forms

If you are unsure of compliance after reviewing the guidelines you may submit your proposed marketing material to HHS for review and approval.

# Specific Marketing Guidelines

| | |
|---|---|
| 1 | Provider must comply with its applicable licensing agency's laws and regulations, including any related to marketing and advertising. |
| 2 | Provider must comply with applicable state and federal laws and regulations, contractual requirements, and other guidance documents. |
| 3 | Provider must comply with provider's contract requirements regarding the use of HHSC's, the State's, or an HHS Agency's name in a media release, public announcement, or other public disclosure. |
| 4 | Marketing materials must be written at or below a sixth grade reading level. |
| 5 | Marketing materials that target the client community must be available in English and Spanish. In addition, any languages of other major population groups in Texas must be made available if requested by a client. |
| 6 | Marketing materials must include the name of the provider and the provider's office location and address. |
| 6 | Marketing materials must not be misleading, inaccurate, or contain misrepresentations. |
| 7 | Marketing materials must not make false, misleading, or inaccurate statements relating to services or benefits. |
| 8 | Marketing materials must not represent that services will be provided at no cost when a Medicaid provider will seek remuneration. |
| 9 | Marketing materials must not offer a Medicaid client or client's parent/legal representative any financial gain or incentives. |
| 10 | Marketing materials must not portray competitors or other providers in a negative manner. |
| 11 | Marketing materials must not contain the HHSC logos or insignias, or make any assertion or statement of endorsement by federal or state governmental agencies. |

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# Permissible and Prohibited Activities

| | Permissible | Prohibited |
|---|---|---|
| 1 | Sending Marketing Materials to every person within a specific zip code, without specifically targeting Medicaid clients. | Unsolicited personal contact such as direct mail, telephone, and door-to-door solicitation. |
| 2 | Sending an appointment reminder to a Medicaid client. | Offering gifts or other inducements designed to influence a client's choice of Provider. |
| 3 | Participation at a health awareness education event and making available branded giveaways valued of no more than 10 dollars, individually. | Providing giveaways or incentives valued at over 10 dollars, individually, or passing out materials. |
| 4 | General dissemination of Marketing Materials via television, radio, newspaper, Internet, or billboard advertisement. | Dissemination of material or any other attempts to communicate intended to influence the Client's choice of Provider. |
| 5 | Provider marketing conducted at:<br>• Community-sponsored educational event<br>• Health fair<br>• Outreach activity or<br>• Other similar community or nonprofit event<br>*And which does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education.* | Sending Marketing Materials to a client to offer inducements or incentives. |
| 6 | Provider marketing for the purpose of:<br>• Providing appointment reminder<br>• Distributing promotional health materials<br>• Providing information about the types of services offered by the provider<br>• Coordination of care | Unsolicited personal contact at a child care facility or any other type of facility; or targeting clients solely because the client receives Medicaid/CHIP benefits. |

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# Provider Resources

# Secure Provider Portal

Cook Children's Health Plan offers an online portal where Providers can access clinical or managed care data.

By granting Providers access to EpicCare Link the amount of paper authorizations, manual claim status requests, and customer service calls are reduced.

Visit cookchp.org to register for our new Secure Provider Portal.

- Select request new account and follow the steps
- Three to five (3-5) business days for the account to be approved
- You will receive an email confirming your registration

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# Secure Provider Portal

Each Provider office must have a Site Administrator.

- The Site Admin will be responsible for submitting account requests for each staff member who requires access and deactivating users who resign or are terminated
- Each staff member must have their **own** unique user name and password

Need assistance in navigating the Secure Provider Portal?

- Register for a webinar by visiting the Provider Relations page located on cookchp.org, select the Provider Training Webinar Schedule
  - Review the calendar and follow the instructions to register for the webinar of your choice

**Please note:** Users who do not long in for ninety (90) days will automatically be disabled due to inactivity.

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# Verification of Eligibility

As a contracted Provider, you are responsible for verifying Member eligibility. Members are enrolled and disenrolled at the beginning of each month.

It is important that you verify Member eligibility before providing services to ensure benefits are in place. A few ways to verify eligibility:

- Health plan identification card
- Secure Provider Portal
  - cookchp.org
- Your Texas Benefits Provider Helpline
  - 855-827-3747
- TexMedConnect
  - tmhp.com

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# Other Health Insurance

Providers are required to file a claim with the Member's primary insurance before submitting the claim to Cook Children's Health Plan.

If the services you are providing are a non covered benefit or the Member has exhausted their benefits you can submit the denial or letter of exhausted benefits to Cook Children's Health Plan via the Secure Provider Portal by submitting a Customer Service Request, select the Topic: OHI Notification.

If a Member has a change in eligibility status you can update Other Health Insurance information via the Secure Provider Portal by submitting a Customer Service Request, select the Topic: OHI Notification.

Providers pending enrollment to the Secure Provider Portal can submit OHI information via secure email to CCHPCOB@cookchildrens.org.

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# Prior Authorizations

Providers must submit prior authorization requests via the Secure Provider Portal.

If you do not have access to the Secure Provider Portal please review the Secure Provider Portal Reference Guide for instructions or email Provider Relations at CCHPProviderRelations@cookchildrens.org for enrollment assistance.

Providers pending enrollment to the Secure Provider Portal may submit a prior authorization request via fax by visiting our Prior Authorization page located at cookchp.org.

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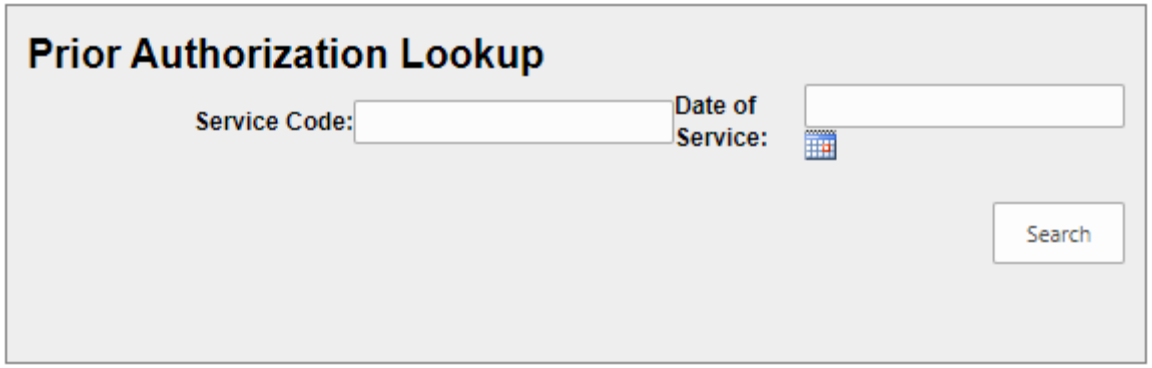
# Prior Authorization Search

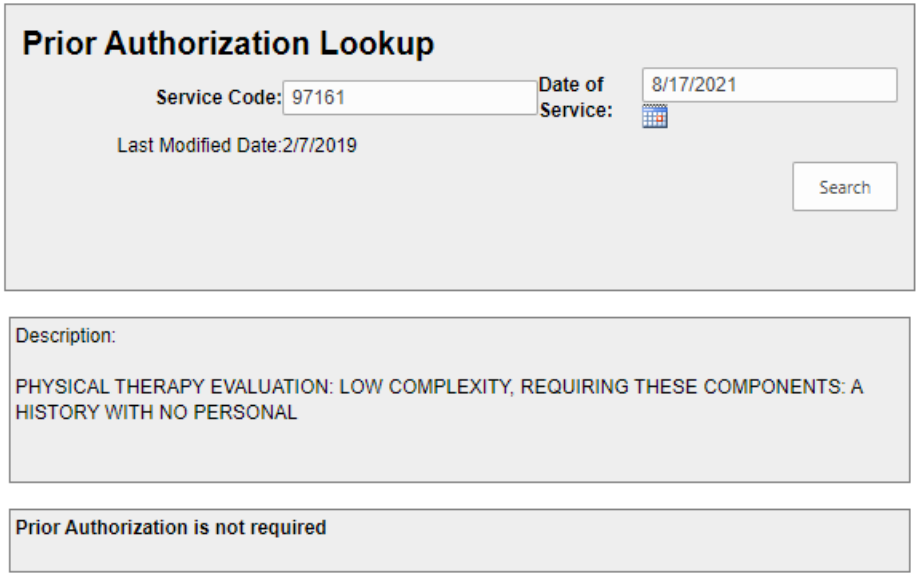
To access the Prior Authorization Search tool located on our website at cookchp.org, select Providers and then select Prior Authorization.




- Enter a valid CPT or HCPC in the service code field and select the date of service from the calendar, then click "search"

# Prior Authorization Not Required

The response **Prior authorization is not required** is not a guarantee of payment.




**Note:** Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions.

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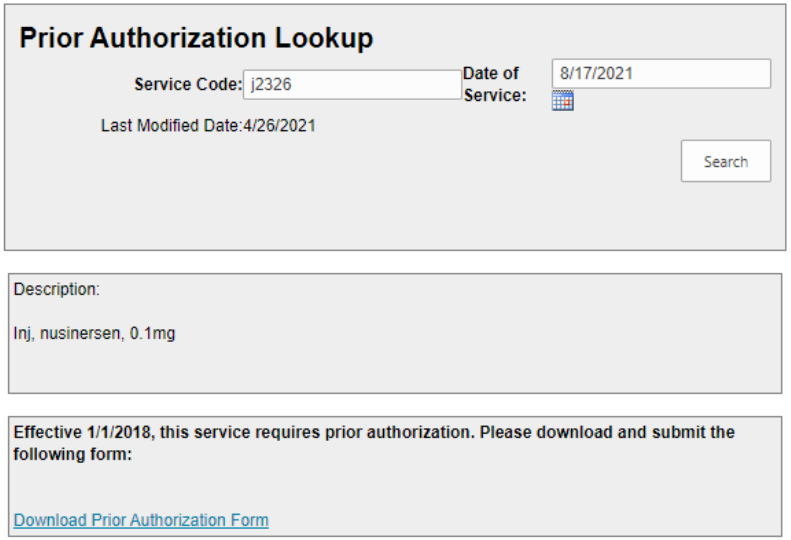
# Prior Authorization Search Response

**Prior Authorization required** requires the Provider to submit a prior authorization request. ***Prior Authorization is not a guarantee of payment.***




**Note:** Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions.

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# Prior Authorization Determination

Prior authorization determination letters are sent to the Provider via the Secure Provider Portal.

- Any Provider representative with access to the Secure Provider Portal and linked to the Provider Tax ID or NPI will access the prior authorization determination via the Secure Provider Portal In Basket
- Prior authorization determination letters will not be faxed

# Authorization Number – Claim Form

If an authorization is required for the service you provided you must submit the claim form with the authorization number in the appropriate field.

Paper Claim Form
- CMS 1500
  - Item 23
- UB-04
  - Form locator 63

Electronic Data Interchange
- Loop 2300, Segment REF

**Note:** Claims submitted without the authorization number will be denied.

# Prior Authorization Reminders

Providers must ensure that all necessary prior authorizations are obtained prior to providing services.

- Payment is subject to the Member's eligibility and benefits on the date of service
- Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions
- Only one authorization number per claim
  - If the services you are billing for have more than one authorization number you will need to split the claim or the service will deny
- The requested Provider on the authorization form must match the way that the Provider is credentialed and contracted with the health plan
- Authorization dates of service, procedure codes, place of service, and modifiers must match the services as billed on the claim form

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# Prior Authorization Required

**Prior Authorization is always required for:**

- Out of network services
  - Except STAR family planning & Texas Health Steps
- Inpatient admissions
  - Not related to STAR Member delivery usual Length of Stay
    - Routine is defined as three (3) days for vaginal deliveries and five (5) days for cesarean deliveries
- Home Health Nursing; Hospice
- Non-Emergency Transport
- Plastic/Reconstruction/Cosmetic Procedures
- Radiation Therapy
- Transplants
- Emergency Dental Treatment for Dental Trauma

# Claim Filing

There are two ways to file a claim – electronically or paper. The required information is the same regardless how you choose to file the claim.

While we highly encourage Electronic Claim Submissions, should you find that you can only submit a claim on paper, please submit your claim to:

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

**Note:** Claims submitted on paper should be sent certified mail

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# Electronic Claim Submission

We are pleased to partner with Availity to provide a secure platform where Providers can submit single claims at no cost.

- You can register or login to Availity's portal by visiting Availity.com
  - Register
  - Login
- For questions, you can call Availity Client Services at 800-282-4548

Cook Children's Health Plan Payor Identification:

- CHIP Payer ID: CCHP1
- STAR/STAR Kids Payer ID: CCHP9

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# Electronic Data Interchange

Primary and secondary claims can be submitted to Cook Children's Health Plan electronically. For Electronic Data Interchange (EDI) requirements please visit cookchp.org and tmhp.com.

The following resources are available to assist Providers with submitting claims electronically:

- TMHP Electronic Data Interchange Companion Guides
- CCHP Electronic Data Interchange Requirements – Institutional
- CCHP Electronic Data Interchange Requirements – Professional
- 837P Acute Care Companion Guide – Professional Claim
- 837I Acute Care Companion Guide – Institutional Claim
- 837P Long Term Care Companion Guide – Professional Claim
- 837I Long Term Care Companion Guide – Institutional Claim

**Note:** These resources should be used in conjunction with the National Implementation Guide.

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# Paper Claim Submission

If you must submit a paper claim:

- Use an official **red** CMS-1500
  - Do not use copies
  - Do not use EMR templates
  - Must submit by mail cannot submit by fax
- Do not fold claim forms
  - Use paper clips
    - Do not use staples or tape
- Print claim data within defined boxes on the claim form
- Use all capital letters
- Send Certified Mail
  - Include a letter with a list that includes the Member Name, Patient Account Number and Date of Service

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# Paper Claim Submission

- Keep a copy of this document with your Certified Mail receipt

**Note:** Tips for submitting a paper claim can be located on our website at cookchp.org, select Providers, Electronic Submission Services and scroll down to Paper Claim Submission.

# Timely Filing Deadline

Timely Filing Deadline Calendars

- Initial claim must be received by the health plan within ninety-five (95) days of the date of service
  - If the claim covers multiple dates, the ninety-five (95) day timely filing is based on the FIRST date of service on the claim form
- Secondary claims must be received by the health plan within ninety-five (95) days from the disposition date on the primary insurance Explanation of Benefits (EOB)
- Corrected claims must be received by the health plan within ninety-five (95) days of the date of service

# Date Span Billing

Cook Children's Health Plan does not allow date span billing.

- Each date of service must have it's own claim line

# Clean Claim

A clean claim is defined as a claim containing all required information needed to process the claim. This includes but is not limited to:

- Primary Insurance EOB
- MSRP Invoice
- Procedure Codes and Modifiers

**Reminder:** Your claim form must include all the required data to adjudicate your claim.

**Note:** A clean claim must be received by the health plan within ninety-five (95) days of the date of service.

# Rejected Claims

Rejected claims do not enter the adjudication system due to missing or incorrect information.

- Rejected claims are not considered "received"
  - They are not accepted for adjudication
  - They do not receive a claim number
- The claim is returned to the Provider along with a rejection letter
- The claim error should be fixed and the new claim submitted to the health plan

# Denied Claims

Denied claims go through the adjudication process, but are denied for payment.

- The Provider must submit a written request for claim reconsideration or a claim appeal
- Claim reconsiderations and claim appeals must be received by the health plan within one hundred twenty (120) days from the date on the health plan's Explanation of Payment

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# Claim Edits

A electronic claim is transmitted through a clearinghouse.

- The clearinghouse runs the claim through front-end edits
- Claims that do not pass these edits are rejected by the clearinghouse and returned to the Provider with a report indicating the claim was rejected
  - The Payer Response Report identifies the rejection reason
- Rejected claims are not received by the health plan
  - The claim error should be fixed and the new claim submitted to the health plan
  - The health plan must receive the claim within ninety-five (95) days of the date of service

# Claim Edits

A paper claim received by the health plan is scanned into a database that performs the front-end edits. If the claim does not pass the edits it is rejected and returned to the Provider with a letter explaining the reason for rejection.

Front-end edits include but are not limited to:

- Eligibility
  - Is there active eligibility for the date of service billed
- Verifying Member information matches the eligibility file
  - Name, Gender, Date of Birth, ID #
- Billing, Attending, Rendering, Referring and Servicing Facility Provider Name
  - Is the Provider's first name and last name listed on the claim
  - Does the Providers name match Texas Medicaid enrollment

# Claim Edits

- Billing, Attending, Rendering, Referring and Servicing Facility Provider NPI
  - Is the appropriate NPI listed on the claim
  - Does the NPI match Texas Medicaid enrollment
  - If the Service Facility Location is the Provider's office or Member's home, leave this field blank
- Billing, Attending, Rendering, Referring, and Service Facility Provider Taxonomy Code
  - Is the Provider taxonomy code listed and is a taxonomy qualifier present
  - Does the taxonomy code match Texas Medicaid enrollment
- Referring Provider must be the individual who directed the patient for care to the Provider rendering the services being reported
  - Is the Provider's first name and last name present
- The Attending, Referring and Rendering Provider cannot be a group
- The Referring & Rendering Provider cannot be the same

# Claim Edits

- Do not enter Self Referral under the Referring Provider
- Primary Diagnosis code
  - Is the ICD-10 valid for the date of service
  - This edit does not determine if the ICD-10 is a benefit of the plan for the service provided, refer to the Texas Medicaid Provider Procedures Manual for benefits, limitations and exclusions
  - Is the ICD-10 appropriate for the Member's age, gender
- Procedure code
  - Is the CPT/HCPC code valid for the date of service
  - Is the code appropriate for the Member's age, gender

**Note:** Claims submitted with incorrect, invalid or missing NPI and Taxonomy code combination will reject or deny. Authorization dates of service, procedure codes, place of service, and modifiers must match services on the claim.

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# Corrected Claim Submissions

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 (95) days of the date of service and can be submitted electronically or by paper
- Must be identified as a corrected claim
- Must reference the original claim number on the corrected claim

**Reminder:** You can locate the original claim number on your electronic remittance advice or on the remittance advice summary via the Secure Provider Portal.

# Corrected Claim – EDI Instructions

CMS 1500

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - 7 = REPLACEMENT (replacement of prior claim)
  - 8 = VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected
  - You can locate the original claim number on your remittance advice

UB04

- The Type of Bill for UB claims are billed in loop 2300/CLM05-1
  - You will replace the third position of the TOB for "frequency"
    - 7 = REPLACEMENT (replacement of prior claim)
    - 8 = VOID (void/cancel of prior claim)

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# Corrected Claim – EDI Instructions

- In the 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected
  - This information can be found on the remittance advice

# Corrected Claim – Paper Instructions

CMS 1500

- Replacement claims
  - Enter resubmission code 7 in Box 22 along with the original claim number (ICN) under Original Ref No
- Voided claims
  - Enter resubmission code 8 in Box 22 along with the original claim number (ICN) under Original Ref No

# Secondary Claim - Electronic Filing

Providers must report paid amounts at both the claim level and service line level to ensure claim integrity. Both levels must balance. There are two different ways the claim information must balance. They are as follows:

Claim Level

- Claim Charge Amounts
  - The total charge amount reported in Loop 2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop 2400 SV203

Claim Payment Amounts

- Balancing of claim payment information is done payer by payer

# Secondary Claim - Electronic Filing

- The sum of all line level payment amounts (Loop 2430 SVC02) less any claim level adjustment amounts (Loop 2320 CAS adjustments) must balance to the claim level payment amount (Loop 2320 AMT02)
  - Expressed as a calculation for given payer: (Loop 2320 AMT02 payer payment) = (sum of Loop 2430 SVD02 payment amounts) minus (sum of Loop 2320 CAS adjustment amounts)
  - The payer's total claim payment is reported within Loop 2320 Coordination of Benefits (COB) Payer Paid Amount (AMT) segment with a D qualifier in AMT01
    - The associated payer is defined within Loop 2330B Other Payer Name, Segment NM1

Line Level Payment Amounts

- Line level payment information is reported in Loop 2430 SVD02

# Secondary Claim - Electronic Filing

- Line level balancing function, the receiver must know which payer the line payment belongs to
  - This is accomplished using the identifier reported in Loop 2430 SVD01
    - This identifier must match the identifier of the corresponding payer identifier reported in Loop 2330B NM109

Service Line Level

- Line Adjudication Information (Loop 2430) is reported when the payer identified in Loop 2330B has adjudicated the claim and service line payments and/or adjustments have been applied
- Line Level Balancing occurs independently for each individual Line Adjudication Information Loop
- In order to balance, the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information Loop must balance to the Provider's charge for the line (Loop 2400 SV203)

# Secondary Claim - Electronic Filing

- The Line Adjudication Information Loop can repeat up to twenty-five (25) times for each line item
- The calculation for each 2430 loops is as follows: (sum of Loop 2430 CAS Service Line Adjustments) plus (Loop 2430 SVD02 Service Line Paid Amount) = (Loop 2400 SVC203 Line Item Charge Amount)

Additional Details:

- Claim Level:
  - Loop 2320 Other Subscriber Information
    - Required when the claim has been adjudicated by the payer identified in Loop 2330B
    - Required when Loop 2010AC is present
      - In this case, the claim is a post payment recovery claim submitted by a subrogated Medicaid agency
    - TR3 Example: AMT*D*411~

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# Secondary Claim - Electronic Filing

Service Line Level:

- Loop 2430 Line Adjudication Information
  - Required when the claim has been previously adjudicated by payer identified in Loop 2330B and this service line has payments and/or adjustments applied to it
- Loop Repeat: 15
- TR3 Notes: To show unbundled lines
  - If, in the original claim, line 3 is unbundled into (for example) two additional lines, then the SVD for line 3 is used three times
    - Once for the original adjustment to line 3 and then two more times for the additional unbundled lines
- TR3 Example: SVD*43*55*HC:84550**3~

# Claim Number Sequence

Cook Children's Health Plan's claim number sequence includes the date the claim was received.

Here is an example of the claim number format:

- 21040100001
  - YYMMDD + five (5) digit claim system generated ID

**Note:** Claims are adjudicated within thirty (30) days of the date the health plan received the claim.

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# Claim Status

To check claim status online you must have access to our Secure Provider Portal. To check claim status via the Secure Provider Portal:

- Visit cookchp.org, select Provider and then select Secure Provider Portal, login
- From the homepage:
  - Click **Select Patient**
  - Locate your patient
  - Click on the ellipses
    - Select **Claim by Member**
  - Select the appropriate **Claim #**
    - To review the details of the claim, click the **Claim #** link
  - The date range defaults to one year, but can be updated if needed

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# Claim Status – Electronic Claims

- Check claim status within seven (7) days of submitting the claim electronically
  - If you are unable to locate the claim on the Secure Provider Portal within seven (7) days of submission
  - Review your Payer Response Report provided to you by your Clearinghouse
    - This report will indicate whether the health plan accepted your claim for adjudication or rejected it due to an edit/error
  - If the claim is rejected the report will identify the rejection reason
  - Make the required corrections and submit the claim

**Reminder:** Rejected claims are not received by the health plan. You must make the needed corrections and resubmit the claim within the timely filing guidelines.

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# Claim Status – Paper Claims

- Check claim status two (2) weeks after submitting the claim to the health plan to verify the claim was received
- If the claim does not appear on the Secure Provider Portal within two weeks of mailing the claim the Provider should resubmit the claim to the health plan to ensure timely filing
  - The claim must be received by the health plan within ninety-five (95) days of the date of service

# Claim Status Reminders

- Providers should check claim status to ensure the claim was received by the health plan
  - It is the Providers responsibility to ensure the claim is received within the timely filing deadline
  - A rejected claim is not a received claim
- Providers can check claim status on our Secure Provider Portal
- Claims are adjudicated within thirty (30) days from the date the health plan receives the claim
  - We recommend you check claim status via the Secure Provider Portal at a minimum every two weeks
- If a claim does not appear on an Explanation of Payment within forty-five (45) days as a paid, denied or incomplete claim, the Provider should resubmit the claim to ensure timely filing

# Reimbursement

Cook Children's Health Plan reimburses claims per the Texas Medicaid Healthcare Partnership fee schedule.

- Providers should follow the benefit limitations, exclusions, and claim filing instructions within the Texas Medicaid Provider Procedures Manual
- Providers should bill their usual and customary rates
  - Do not bill less than the contracted reimbursement rate
  - If a Provider bills less than the contracted rate, the claim reimburses up to the Providers billed charge
- Claims are reimbursed based on the contracted rate schedule
- Provider's agree to accept the reimbursement rate as payment in full for services rendered to Medicaid Members

Cook Children's Health Plan

# Claim Overpayments and Refunds

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.

- Visit cookchp.org, select Providers, then select Secure Provider Portal
  - Complete a Customer Service Request
    - Select the Topic: Submit a Claim Appeal

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 (EOP).

Cook Children's Health Plan

# Claim Overpayments and Refunds

Providers can submit refund checks to:

Cook Children's Health Plan

Attention: Finance Department

PO Box 2488

Fort Worth, TX 76113-2488

Cook Children's Health Plan

# Claim Reconsideration

A Claim Reconsideration is submitted when the claim was denied because additional information is needed to adjudicate the claim. A written request for reconsideration must be received within one hundred twenty (120) days of the disposition date on the health plan's Explanation of Payment (EOP).

When submitting a reconsideration request you must provide a **clear written description** of what you are asking the health plan to re-review and the outcome you are expecting.

Here are example components that a Provider may send for Claim Reconsideration:

- Change in Member eligibility status
- Primary Insurance Explanation of Benefits
- Invoice or MSRP

Cook Children's Health Plan

# Submit a Claim Reconsideration

Providers should submit claim reconsideration requests online via our Secure Provider Portal by completing a Customer Service Request.

- Visit cookchp.org, select Providers, then select Secure Provider Portal
  - Complete a Customer Service Request
    - Select the Topic: Submit a Claim Reconsideration
  - You will receive a CRM number for tracking purposes in your In Basket

# Status of a Claim Reconsideration

Status of a claim reconsideration is not available via the Secure Provider Portal once the customer service request has been submitted.

- Claim Reconsideration Decision
  - Allow thirty (30) days from the date the claim reconsideration was received for processing
  - If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
  - If the initial claim decision is upheld a letter will be mailed to the Provider
- Claim Reconsideration Status
  - If it's been more than forty-five (45) days from the date you submitted the request you may call or email our Claims Department for status

# Status of a Claim Reconsideration

- Phone
  - 888-243-3312
- Email
  - CCHPClaimsTeam@cookchildrens.org

Please be prepared to provide your Customer Relationship Management Number (CRM) to our Claims Department when asking for status of the claim reconsideration.

# Claim Appeal

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.** This means the claim was adjudicated and denied.

A written appeal must be received within one hundred twenty (120) days of the disposition date on the health plan Explanation of Payment (EOP). When submitting a claim appeal you must provide a **clear written description** of what you are asking the health plan to re-review and the outcome you are expecting.

Cook Children's Health Plan

# Claim Appeal

**Reminders:**

- Changes or errors in CPT codes are not considered payment appeals
  - This is considered to be a corrected claim, corrected claims must be received by the health plan within ninety-five (95) days of the date of service

# Submit a Claim Appeal

Providers should submit claim appeals online through our Secure Provider Portal by completing a Customer Service Request.

- Visit cookchp.org, select Providers, then select Secure Provider Portal
  - Complete a Customer Service Request
    - Select the Topic: Submit a Claim Appeal
  - You will receive a CRM number for tracking purposes in your In Basket

Cook Children's Health Plan

# Status of a Claim Appeal

Status of a claim appeal is not available via the Secure Provider Portal.

- Claim Appeal Decision
  - If the initial claim decision is overturned the claim will be readjudicated and a new claim number will be issued
  - If the initial claim decision is upheld a letter will be mailed to the Provider
- Claim Appeal Status
  - If it's been more than forty-five (45) days from the date you submitted the request call or email our Claims Department for status

# Status of a Claim Appeal

- Phone
  - 888-243-3312
- Email
  - CCHPClaimsTeam@cookchildrens.org

Please be prepared to provide your Customer Relationship Management Number (CRM) to our Claims Department when asking for status of the claim reconsideration.

# Appeal Supporting Documentation

- Letter from the Provider stating why you feel the claim payment is incorrect (required)
- A copy of the original claim
- A 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
- Proof of eligibility
- If appealing a timely filing denial include:
  - 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

Cook Children's Health Plan

# Reconsideration & Appeal Submission

Electronically: Secure Provider Portal

- Customer Service Request
  - Topic: Submit a Claim Reconsideration
  - Topic: Submit a Claim Appeal

Fax: 682-885-8404

Email: CCHPClaimAppeals@cookchildrens.org

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

Cook Children's Health Plan

# Complaints Process

Providers who wish to file a complaint about Cook Children's Health Plan may do so by following the Provider Complaint Process.

- Upon receipt of a written 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 (30) 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 (7) years

Providers have the right to file a complaint with HHS and must send a letter within sixty (60) calendar days of receiving the health plan's resolution letter.

Cook Children's Health Plan

# Complaints Process

- Your letter must explain the specific reasons you believe Cook Children's Health Plan's complaint resolution is incorrect and provide the following supporting documentation
- Any items you submitted to or received from the health plan including copies of supporting documentation, the original claim, the health plan's Explanation of Payment, claims processing discrepancies, certified mail receipts, original date-stamped envelopes, notes and logs

Cook Children's Health Plan

# Complaints Submission – Health Plan

- Secure Provider Portal
  - Customer Service Request. Topic: Submit a Provider Complaint
- Fax written complaint to: 682-885-2148
- Email written complaint to: CCHPCompliance@cookchildrens.org
- Mail written complaint to: Cook Children's Health Plan
  Attn: Compliance
  P.O. Box 2488
  Fort Worth, TX 76113-2488
- Phone: 682-885-2866

Cook Children's Health Plan

# Complaints Submission - HHSC

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

# Medical Necessity Appeal

Cook Children's Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests.

- For more information please visit the Complaints and Appeals page or the Manuals and Forms page located on our website at cookchp.org

Cook Children's Health Plan

# Provider Appeal Process – HHSC

Providers may appeal a claim recoupment related to a managed care disenrollment by submitting an exception request to HHSC.

- For more information please visit the Complaints and Appeals page or the Manuals and Forms page located on our website at cookchp.org

# Cook Children's Health Plan Website

There are many other resources available to our Providers by visiting our Provider website at cookchp.org.

- Providers
  - Provider Relations
  - Pharmacy Information
  - Prior Authorization
  - Therapy Information
  - Resources
  - Provider Manuals and Forms
  - Provider News
    - Including our Quarterly Provider Newsletter(s)
  - Secure Provider Portal

Cook Children's Health Plan

# Provider Education and Training

In our ongoing effort to provide web-based services you can now find self-paced training presentations on our website, cookchp.org, select Provider, Provider Relations, scroll down to training presentations and select the training you'd like to view.

The most current provider training webinar schedule is located on the Provider Relations page on our website cookchp.org.

- Webinars are scheduled from 12pm - 1pm CT
  - Dates and times are subject to change
- You can register for a webinar at anytime
  - You do not need to wait until the day of the event

Cook Children's Health Plan

# Provider Advisory Group

# Provider Advisory Group

Providers are welcome to participate in Cook Children's Health Plan Provider Advisory Group. The Provider Advisory Group meets quarterly and gives Providers an opportunity to share feedback and suggestions with the health plan.

If you are interested in joining the Advisory Group, you may register for the meeting by visiting our Provider Relations page, select the provider training webinar schedule, and select the registration link for the upcoming Advisory webinars you choose to attend.

Cook Children's Health Plan

# Products, Programs and Services

# State of Texas Access Reform Medicaid (STAR)

Cook Children's Health Plan

# STAR Eligibility

STAR's eligibility and enrollment is managed by Maximus the Administrative Contractor for Health and Human Services.

Eligibility criteria

- Resident of the State of Texas
- U.S. citizen or legal permanent resident
- Meet financial guidelines (percentage of Federal Poverty Level)
- All ages

Enrollment

- Member income qualification & enrollment information is available online at Your Texas Benefits

There are no copayments for STAR Members.

Cook Children's Health Plan

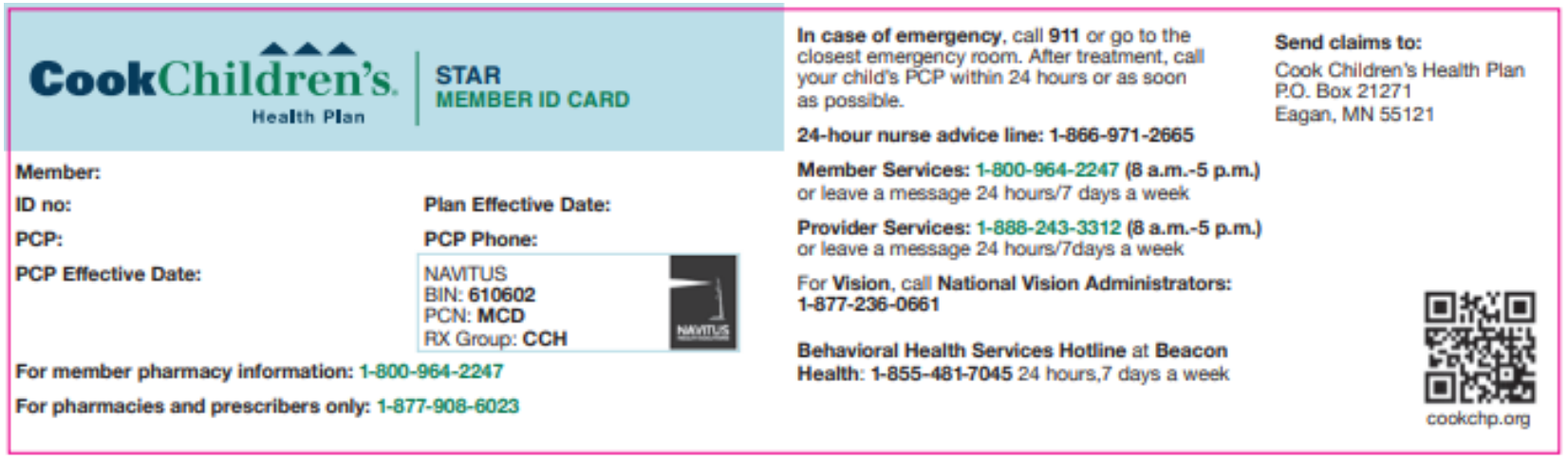
# Newborn Eligibility – STAR Program

- Automatically enrolled
  - In the managed care plan the Mother is enrolled in at the time of the newborn's birth for a period of ninety (90) days
- Mother can request a health plan change by calling the Enrollment Broker
  - Mother cannot change from one health plan to another during an inpatient stay

# Newborn Claims Filing

- Newborn claims must be filed to Cook Children's Health Plan with the Newborn's ID number or the claim will deny
- Providers filing claims for services provided to newborns are still responsible for meeting timely filing deadlines
  - The health plan must receive the claim within ninety five (95) days of the date of service
- If you file a claim for the newborn under the Mother's ID the claim will deny
  - The claim will need to be resubmitted with the newborn claim ID number

# STAR Member Identification Card



CookChildren's Health Plan | STAR MEMBER ID CARD

Member:

ID no:

PCP:

PCP Effective Date:

Plan Effective Date:

PCP Phone:

NAVITUS
BIN: 610602
PCN: MCD
RX Group: CCH

For member pharmacy information: 1-800-964-2247

For pharmacies and prescribers only: 1-877-908-6023

**In case of emergency**, call **911** or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

**24-hour nurse advice line: 1-866-971-2665**

**Member Services: 1-800-964-2247 (8 a.m.-5 p.m.)** or leave a message 24 hours/7 days a week

**Provider Services: 1-888-243-3312 (8 a.m.-5 p.m.)** or leave a message 24 hours/7days a week

For **Vision**, call **National Vision Administrators: 1-877-236-0661**

**Behavioral Health Services Hotline** at **Beacon Health**: **1-855-481-7045** 24 hours,7 days a week

**Send claims to:**
Cook Children's Health Plan
P.O. Box 21271
Eagan, MN 55121

cookchp.org

CookChildren's Health Plan

# STAR Covered Services

For a complete list of covered services and limitations please visit tmhp.com to review the Texas Medicaid Provider Procedures Manual.

- Medical checkups (Texas Health Steps)
- Primary and Specialty Physician Services
- Prenatal care
- Vision
- Therapies – physical, occupational and speech
- Drugs and biologicals
- Behavioral health services
- Durable medical equipment and supplies
- Family planning services
- Home health care services
- Inpatient and outpatient hospital services

Cook Children's Health Plan

# STAR Kids

Cook Children's Health Plan

# STAR Kids

STAR Kids is a Texas Medicaid Managed Care program that began in 2016. It is a program mandated to provide Medicaid Benefits to individuals with disabilities under the age of twenty-one (21).

- The program provides comprehensive medical benefits, behavioral health benefits, and service coordination
- Children and youth who receive long term services and supports through MDCP waiver will have this waiver managed under STAR Kids and the Managed Care Organization (MCO)
- Families can expect collaborative person centered care with the health plan providing service coordination, focused at identifying needs and connecting Members to services and qualified Providers
- All STAR Kids Member's will have an assessment to drive and formulate an agreed upon individual service plan (ISP)

Cook Children's Health Plan

# STAR Kids Eligibility

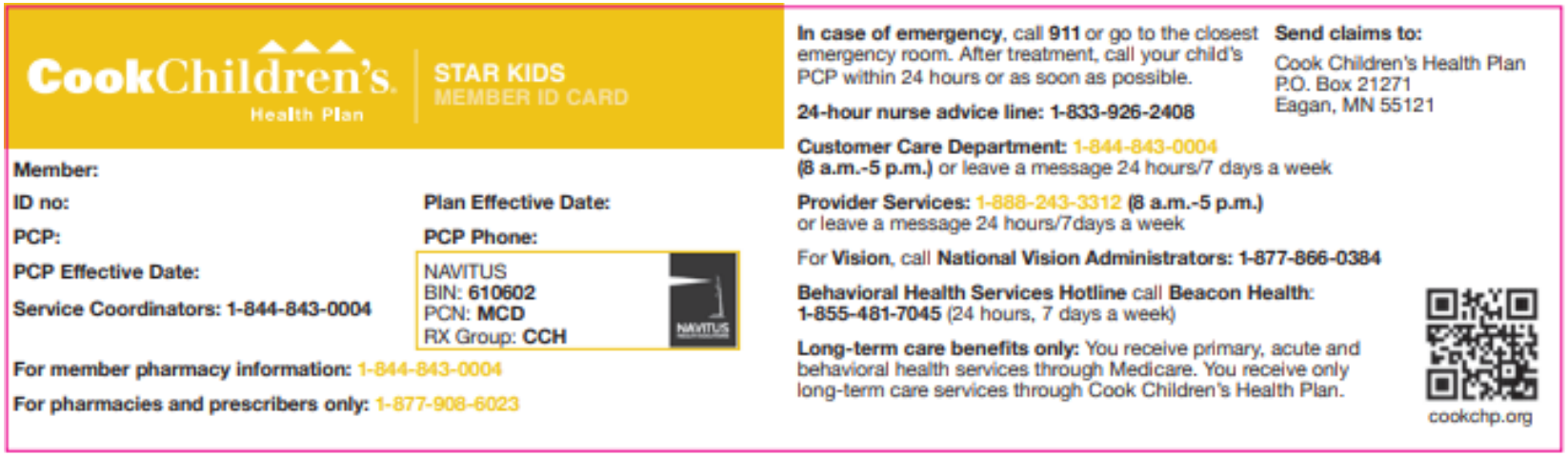
Participation in the STAR Kids program is required for those who are twenty (20) years of age or younger, covered by Medicaid, and meet at least one of the following:

- Get Supplemental Security Income (SSI)
- Get SSI and Medicare
- Get services through the Medically Dependent Children Program (MDCP) waiver
- Get services through the Youth Empowerment Services (YES) waiver
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility
- Get services through a Medicaid Buy-In program

# STAR Kids Eligibility

- Get services through any of the following waiver programs:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities (DBMD)
  - Home and Community-based Services (HCS)
  - Texas Home Living (TxHmL)

# STAR Kids Member Identification Card



CookChildren's Health Plan

STAR KIDS
MEMBER ID CARD

**Member:**

**ID no:**

**PCP:**

**PCP Effective Date:**

**Service Coordinators: 1-844-843-0004**

**Plan Effective Date:**

**PCP Phone:**

NAVITUS
BIN: **610602**
PCN: **MCD**
RX Group: **CCH**

**For member pharmacy information:** 1-844-843-0004

**For pharmacies and prescribers only:** 1-877-908-6023

**In case of emergency**, call **911** or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

**24-hour nurse advice line: 1-833-926-2408**

**Send claims to:**
Cook Children's Health Plan
P.O. Box 21271
Eagan, MN 55121

**Customer Care Department:** 1-844-843-0004
**(8 a.m.-5 p.m.)** or leave a message 24 hours/7 days a week

**Provider Services:** 1-888-243-3312 **(8 a.m.-5 p.m.)**
or leave a message 24 hours/7days a week

For **Vision**, call **National Vision Administrators: 1-877-866-0384**

**Behavioral Health Services Hotline** call **Beacon Health**:
**1-855-481-7045** (24 hours, 7 days a week)

**Long-term care benefits only:** You receive primary, acute and behavioral health services through Medicare. You receive only long-term care services through Cook Children's Health Plan.

cookchp.org

CookChildren's Health Plan

# STAR Kids Covered Services

These are examples only and are by no means the exhaustive list. For a complete list of covered services and limitations please visit tmhp.com to review the Texas Medicaid Provider Procedures Manual.

- Therapy
- Durable Medical Equipment & Medical Supplies
- Private Duty Nursing & Skilled Nursing Visits
- Skilled nursing visits
- Nutritional counseling & Counseling services with a licensed professional
- Orthotics & Prosthetics
- Vision
- Hearing

Cook Children's Health Plan

# STAR Kids Covered Services

- Inpatient Psychiatric Services
- Inpatient Rehabilitation
- Extended Hospitalization

# Texas Health Steps

# Texas Health Steps

What is a Texas Health Steps (THSteps)?

- Medical checkups and preventive services for Medicaid (STAR & STAR Kids) Members birth through twenty (20) years of age
- THSteps are not available as Telemedicine or Telehealth Services
  - For (COVID-19) Guidance for THSteps please visit tmhp.com

For a more in depth training please visit the Texas Health Steps and Provider Relations pages located at cookchp.org.

Texas Health Steps Provider Resources:

- tmhp.com
- dshs.gov

Cook Children's Health Plan

# Children of Migrant Farm Workers

# Children of Migrant Farm Workers

Special Medicaid Services exists for children of Migrant Farm Workers:

- A migrant farm worker is a person who works on farms in fields or as a food packer during certain times of the year
- Please notify us so we can make sure they get expedited appointments
- We can assist with:
  - Scheduling appointments
  - Finding a Primary Care Provider or after-hours clinic
  - Finding affordable insurance for Members of their household without coverage
  - Locating free transportation
  - Information regarding government programs

Texas migrant children face higher proportions of dental, nutritional and chronic health problems than non migrant children.

CookChildren's Health Plan

# Children's Health Insurance Program (CHIP)

Cook Children's Health Plan

# CHIP Eligibility

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:

- U.S. citizen or legal permanent resident (child)
- Under age nineteen (19)
- Uninsured for at least ninety (90) days
- Living in a family with income at or below 201% of Federal Poverty Level (FPL)
- Anyone age nineteen (19) or younger living on their own may apply

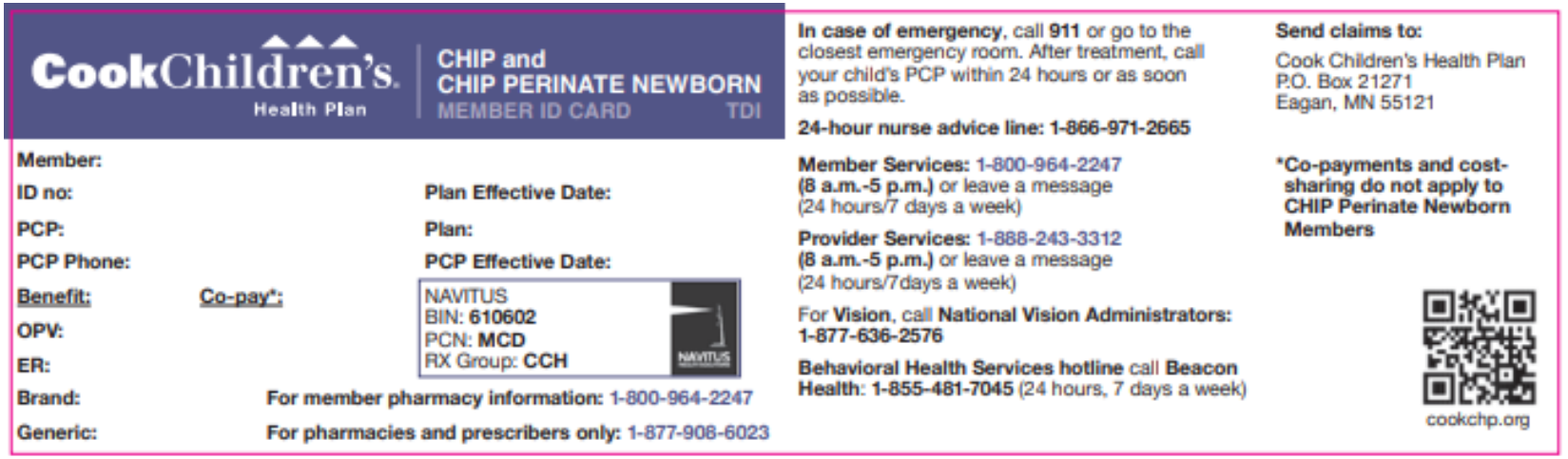
Cook Children's Health Plan

# CHIP Eligibility

Disenrollment:

- Member turns nineteen (19)
- Member does not re-enroll by the end of the twelve (12) month coverage period
- Member does not pay premium
- Member is covered under another health plan through an employer
- Death of Member
- Member moves out of state
- Member is enrolled in Medicaid

# CHIP Member Identification Card



CookChildren's Health Plan

CHIP and
CHIP PERINATE NEWBORN
MEMBER ID CARD TDI

Member:
ID no:
PCP:
PCP Phone:
Benefit: Co-pay*:
OPV:
ER:
Brand:
Generic:

Plan Effective Date:
Plan:
PCP Effective Date:

NAVITUS
BIN: 610602
PCN: MCD
RX Group: CCH

For member pharmacy information: 1-800-964-2247
For pharmacies and prescribers only: 1-877-908-6023

**In case of emergency**, call **911** or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

**24-hour nurse advice line: 1-866-971-2665**

**Member Services:** 1-800-964-2247 **(8 a.m.-5 p.m.)** or leave a message (24 hours/7 days a week)

**Provider Services:** 1-888-243-3312 **(8 a.m.-5 p.m.)** or leave a message (24 hours/7days a week)

For **Vision**, call **National Vision Administrators: 1-877-636-2576**

**Behavioral Health Services hotline** call **Beacon Health: 1-855-481-7045** (24 hours, 7 days a week)

**Send claims to:**
Cook Children's Health Plan
P.O. Box 21271
Eagan, MN 55121

***Co-payments and cost-sharing do not apply to CHIP Perinate Newborn Members**

cookchp.org

CookChildren's Health Plan

# CHIP Covered Services

Depending on a family's income, a copayment may be required from the Member for certain covered services.

Covered services for CHIP Members must meet the CHIP definition of medically necessary. Medically necessary services include, but are not limited to:

- Inpatient Hospital
- Skilled Nursing Facilities
- Outpatient Hospital
- Physician Services
  - Acute and Well Child
- Emergency Services

Cook Children's Health Plan

# CHIP Covered Services

- Prescription Drugs
- Chiropractic Services
- Vaccines
- Medical Supplies
- X-rays
- Lab Tests
- Dental
- Vision

# CHIP Perinatal Program

# CHIP Perinatal Program

CHIP Perinatal Program is a subprogram of CHIP and is for unborn children of women who are not eligible for Medicaid and who have household income up to 200% of the Federal Poverty Level (FPL).

Once born, the child will receive Medicaid or CHIP benefits, depending on their the income.

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, family practitioners, nurse practitioners, internists and nurse midwives

# CHIP Perinatal Eligibility & Coverages

Who is eligible? Unborn children of pregnant women who:

- Are a Texas resident
- Does not have other health coverage
- Is unable to qualify for Medicaid
- Has a household income greater than 198% of Federal Poverty Level (FPL) but less than 202% of FPL

CHIP Perinatal coverage for the unborn child includes:

- Prenatal Care
  - Up to twenty (20) Prenatal Visits
- Some lab testing, assessments, planning services, education and counseling
- Prescription drug coverage including prenatal vitamins

Cook Children's Health Plan

# CHIP Perinatal Eligibility & Coverages

- Diabetic Supplies
- Labor and Delivery
  - Hospital Facility charges and professional service charges related to delivery
- Two postpartum visits
  - Within sixty (60) days after delivery or end of pregnancy

**Reminder:** CHIP Perinatal coverage terminates the month of birth, however mom's are still entitled to two post partum visits. These visits should be billed to the health plan for reimbursement.

# CHIP Perinatal Eligibility & Coverages

CHIP Perinatal coverage does not include:

- Inpatient hospital care for the mother of the unborn child that is not related to labor with delivery such as serious injury, illness and more
- Labor without delivery of the baby (false or premature labor)
- Most outpatient specialty services, such as a mental health and substance abuse treatment, asthma management and cardiac care

A pregnant woman may apply for Emergency Medicaid in emergency situations.

# CHIP Perinatal Member Identification Card

CookChildren's Health Plan

CHIP PERINATAL
MEMBER ID CARD
TDI

**Member:**

**ID no:**

**Plan Effective Date:**

**Member's Category:**

**Category A:** 0% to 186%
Federal Poverty Level (FPL)

**Category B:** 186% to 201%
Federal Poverty Level (FPL)

NAVITUS
BIN: **610602**
PCN: **MCD**
RX Group: **CCH**

**For member pharmacy information:** 1-800-964-2247

**For pharmacies and prescribers only:** 1-877-908-6023

**In case of emergency,** call **911**
or go to the closest emergency room.

**24-hour nurse advice line:**
**1-866-971-2665**

**Member Services:** 1-800-964-2247
**(8 a.m.-5 p.m.)** or leave a message
(24 hours/7 days a week)

**Provider Services:** 1-888-243-3312
**(8 a.m.-5 p.m.)** or leave a message
(24 hours/7 days a week)

**Send Hospital Facility Billing claims**
for members that are **Category A** to:

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

**Send Hospital Facility Billing claims**
for members that are at or above
**Category B** or Professional/other
services for all members regardless of
FPL percentage to:

Cook Children's
Health Plan
P.O. Box 21271
Eagan, MN 55121

cookchp.org

CookChildren's Health Plan

# CHIP Perinate Newborn

# CHIP Perinate Newborn

A CHIP Perinate Newborn is eligible for twelve (12) months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven months).

A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

Qualify:

- U.S. citizen or legal permanent resident
- Uninsured for at least ninety (90) days
- Living in a family with income at or below 201% of Federal Poverty Level (FPL)

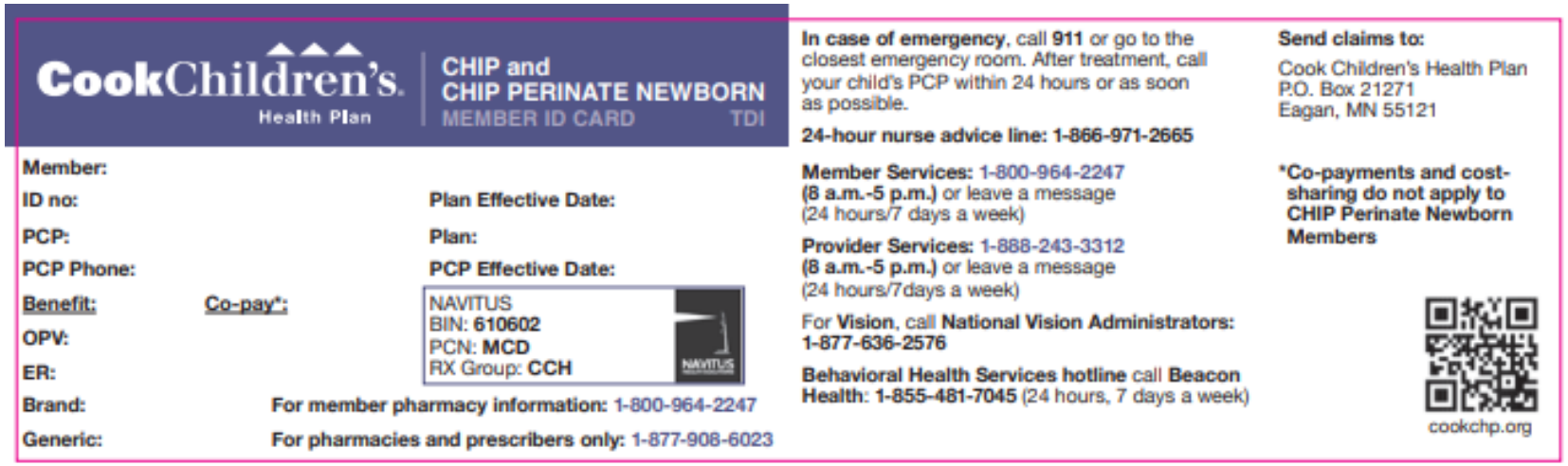
Cook Children's Health Plan

# CHIP Perinate Newborn

Disenrollment:

- Member does not re-enroll by the end of the twelve (12) month coverage period
- Member does not pay premium
- Death of Member
- Member moves out of state
- Member is enrolled in Medicaid

# CHIP Newborn Member ID Card



CookChildren's Health Plan

CHIP and
CHIP PERINATE NEWBORN
MEMBER ID CARD TDI

Member:
ID no:
PCP:
PCP Phone:
Benefit: Co-pay*:
OPV:
ER:
Brand:
Generic:

Plan Effective Date:
Plan:
PCP Effective Date:

NAVITUS
BIN: 610602
PCN: MCD
RX Group: CCH

For member pharmacy information: 1-800-964-2247
For pharmacies and prescribers only: 1-877-908-6023

**In case of emergency**, call **911** or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

**24-hour nurse advice line: 1-866-971-2665**

**Member Services:** 1-800-964-2247 **(8 a.m.-5 p.m.)** or leave a message (24 hours/7 days a week)

**Provider Services:** 1-888-243-3312 **(8 a.m.-5 p.m.)** or leave a message (24 hours/7days a week)

For **Vision**, call **National Vision Administrators: 1-877-636-2576**

**Behavioral Health Services hotline** call **Beacon Health: 1-855-481-7045** (24 hours, 7 days a week)

**Send claims to:**
Cook Children's Health Plan
P.O. Box 21271
Eagan, MN 55121

***Co-payments and cost-sharing do not apply to CHIP Perinate Newborn Members**

cookchp.org

CookChildren's Health Plan

# Value Added Services

# Value Added Services

Providers can view Value Added Services at cookchp.org, select Members, and the product (STAR, STAR Kids, and CHIP) you wish to review.

# Telecommunication Services

# Telecommunication Services

When submitting services for reimbursement Providers should refer to the Telecommunication Services Handbook located on tmhp.com.

- For exceptions due to COVID 19 please visit the Coronavirus (COVID-19) Information pages on TMHP and HHSC
- Telecommunication Services should be billed using modifier 95

# Healthy Texas Women Program

Cook Children's Health Plan

# Healthy Texas Women

Healthy Texas Women is a program dedicated to offering women's health and family planning at no cost to eligible women in Texas.

For in depth information on the Healthy Texas Women visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Healthy Texas Women.

# Family Planning Program

# Family Planning Program

The Family Planning Program is dedicated to providing accessible family planning and reproductive healthcare to eligible women and men in Texas.

For in depth information on the Family Planning Program visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Family Planning Program.

# Interpreter Services

# Interpreter Services

Cook Children's Health Plan wants to be able to meet the diverse needs of our Members. In addition to providing all of our published and website information in English and Spanish, we also offer in-office Interpreter Services for our Members.

If you do not have someone to translate for a Member during their appointment, the health plan will provide Sign Language and/or Face to Face Interpreter Services in person or over the phone.

- Translations are available of most of the commonly spoken languages around the world

Cook Children's Health Plan

# Interpreter Services

- In person Interpreter Services requires a three to four (3-4) day advance notice
  - If less than three (3) day notice
    - The health plan cannot guarantee an Interpreter will be available for last minute requests
- Appointment cancelations must be reported to the health plan as soon as the Member cancels or changes the appointment
  - If an interpreter is not canceled, the health plan is still charged for the service
- Providers may request an Interpreter
  - Secure Provider Portal by submitting a Customer Service Request
    - Topic: Request Interpreter
  - Provider Support Services at 888-243-3312
  - Email - CCHPInterpreterRequest@cookchildrens.org

Cook Children's Health Plan

# Vendors

# Non-Emergency Medical Transportation

Cook Children's Health Plan

# Access2Care

Access2Care provides non-emergency medical transportation to covered health care services for Members who have no other means of transportation.

This includes:

- Rides to the doctor
- Dentist
- Hospital
- Pharmacy
- Does NOT include ambulance trips

# Access2Care Contact Information

If you have a Member you think would benefit from receiving Access2Care, please refer him or her to Access2Care at 844-572-8195 for more information.

# Behavioral Health Services

Cook Children's Health Plan

# Beacon Health Options

Behavioral Health Services is available through Beacon Health Options.

Beacon Health Options can assist you with:

- Locating behavioral health Providers
- Making an urgent appointment
- Arranging an appointment in a timely manner
- Checking a Member's benefits and eligibility

Beacon Health Options can be contact by:

Phone: 855-481-7045

Fax: Main: 855-371-9227

Email: TexasProviderRelations@beaconhealthoptions.com

Website: https://www.beaconhealthoptions.com/providers/dashboard/

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# Beacon Health Options

For more in depth information on Behavioral Health Services visit our website cookchp.org, select Providers, Provider Relations, scroll down to Behavioral Health Focusing on Anxiety and Depression.

Resources:

- Texas Primary Care Toolkit
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Psychological Care for Children and Adolescents on Antipsychotics Measure
- Behavioral Health Services

Cook Children's Health Plan

# Substance Use Disorder Services

Substance Use Disorder (SUD) services are chronic, relapsing medical illnesses that require an array of best practice medical and psycho-social interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs and other substances that may be identified in the future.

Treatment for SUD is a benefit of Texas Medicaid for persons who meet the criteria for a substance related disorder, as outlined in the current edition of the American Psychiatric Association's DSM.

SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat a person's problematic use of alcohol or other drugs, including prescription medication.

# SUD Treatment Options

Substance Use Disorder services may include:

- Withdrawal management services.
- Individual and group SUD counseling in an outpatient setting.
- Residential treatment services.
- Medication assisted treatment.
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions

# SUD Screening Tools

Medical providers are encouraged to screen for both mental health and substance use disorders by using a screening tool such as:

- AUDIT
- CAGE-AID
- CRAFFT
- Modified Mini Screening Tool
- NIDA Quick Screen and Modified Assist

# Opioid Use Disorder Treatment

Medication Assisted Treatment is the use of FDA approved medications in combination with psychosocial treatment to treat substance use disorders, particularly alcohol and opioid use disorders.

Medical providers are encouraged to screen for both mental health and substance use disorders, especially when prescribing pain medication. Providers should use a practice guidelines such as:

- National Practice Guidelines for the Treatment of Opioid Use Disorder
- Centers for Disease Control and Prevention Guideline guideline for prescribing opioids for chronic pain

# SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT is used for intervention directed to a person and not for group intervention.

A Member may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

# SBIRT Screening

Screening Members for problems related to alcohol or substance use identifies the Member's level of risk and determines the appropriate level of intervention indicated for the Member.

Providers must explain the screening results to the Member, and if the results are positive, be prepared to subsequently deliver, or delegate to another Provider, brief intervention services.

Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

# SBIRT Screening Tools

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk

# SBIRT Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use.

Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

# SBIRT Referral to Treatment

If the Provider determines that the Member is in need of more extensive treatment or has a severe risk for alcohol or substance use, the Member must be referred to an appropriate substance use treatment Provider.

Referral is an essential component of the SBIRT intervention because it ensures that all Members who are screened have access to the appropriate level of care.

Note: If the Member is currently under the care of a Behavioral Health Provider, the Member must be referred back to that Provider.

Resource:

Texas Medicaid Provider Procedures Manual

Behavioral Health and Case Management Services Handbook

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# Primary Care Screening & Referral

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 Disability (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.

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.

# Screening & Assessment Instruments

Primary Care Providers are encouraged to screen for both mental health and substance use disorders by using a screening tools such as:

- PHQ-2, PHQ-9, PHQ A
- GAD7
- Patient Stress Questionnaire
- MDQ
- C-SSRS
- ADHD Rating scale-IV
- NICHQ Vanderbilt Assessment Scales
- M-CHART-R
- SCOFF
- Screening for Obsessive-Compulsive Disorder
- PC-PTSD ( Primary Care PTSD Screen)
- PSSI ( PTSD Symptom Scale Interview)
- PCL-C ( PTSD Checklist – Civilian Version)

# Screening & Assessment Instruments

- AUDIT-PC
- CAGE-AID
- CRAFFT
- NIDA

# Pharmacy Services

# Texas Preferred Drug List

Formulary

- Everyone enrolled in Medicaid adheres to the same formulary
- The Medicaid formulary includes legend and over-the-counter drugs
  - Certain supplies, vitamins, and minerals are available as a pharmacy benefit
- Some drugs are subject to prior authorization
  - Clinical or non-preferred

Formulary Drug Search

- Identifies Medicaid covered drugs
- Identifies if the drugs require prior authorization

# Texas Preferred Drug List

Medicaid Preferred Drug List:

- Arranged by therapeutic class
- May contain a subset of drugs on the Medicaid formulary
- Drugs identified as "preferred" are available without prior authorization unless there is a clinical prior authorization associated
- Some drugs may be subject to both non-preferred or clinical prior authorizations
- Is updated twice a year usually in January and July
- CHIP drugs are not subject to the Preferred Drug List requirements

Preferred Drug List Criteria Guide:

- Explains the criteria used to evaluate prior authorization requests
- Drugs listed as "non-preferred" require prior authorization

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# Clinical Prior Authorization

Clinical prior authorizations may apply to any individual drug or an entire drug class on the formulary, including some preferred and non-preferred drugs.

- HHSC requires the health plan to perform specific clinical prior authorizations
- Clinical Prior Authorizations allowed in Medicaid Managed Care
  - Performed for Members enrolled in Medicaid or CHIP
- Clinical prior authorizations active in Medicaid fee-for-service

Clinical Prior Authorization Assistance Chart

- Identifies which health plan's utilize each clinical prior authorization

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# Continuing Education Course

Texas Health Steps offers free online courses the Prescriber's Guide to Texas Medicaid Outpatient Pharmacy Prior Authorization quick course is now available.

# Navitus

Cook Children's Health Plan Members receive pharmacy services through Navitus, the contracted Pharmacy Benefit Manager.

Navitus has a statewide network of contracted pharmacies who are enrolled in the Texas Vendor Drug Program (VDP), including all 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 our website, cookchp.org
- Providers can call Provider Services at 888-243-3312 for assistance in locating a network pharmacy
- A list of covered drugs and preferred drugs may also be accessed through our Navitus Health Solutions

Cook Children's Health Plan

# Navitus

- Medicaid Members receive prescriptions at no cost
- CHIP Members will have a copay
- To locate a network pharmacy:
  - Visit cookchp.org
    - Search Provider/pharmacy
- Prior Authorizations
  - Navitus processes pharmacy prior authorizations for Cook Children's Health Plan
    - Visit the Navitus Prescriber Portal
  - The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC

# Navitus

- Reimbursement
  - Pharmacies should submit for reimbursement of a seventy-two (72) hour emergency prescription supply by utilizing the format provided in the Cook Children's Health Plan Provider Manual
- Navitus may be contacted at 877-908-6023

Cook Children's Health Plan

# Navitus Provider Services

Website: Navitus.com

Provider Portal: Prescriber Portal Log In

Fax: 866-808-4649

Email: providerrelations@Navitus.com

Prior Authorizations: 877-908-6023

Navitus Texas Provider Hotline: 877-908-6023

# 72 Hour Emergency Prescription

A seventy-two (72) 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 (72) hour emergency supply should be dispensed any time a prior authorization cannot be resolved within twenty-four (24) hours for a medication on the Vendor Drug Program formulary that is appropriate for the Member's medical condition
- If the prescribing Provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency seventy-two (72) hour prescription
- Call Navitus toll free 877-907-6023 for more information about the seventy-two (72) hour emergency prescription supply

CookChildren's Health Plan

# Pharmacy Information

Visit the Pharmacy Information page located on our website at cookchp.org for Pharmacy Information Services.

The following Pharmacy Information can be found on Navitus website:

- Clinical edits
- Formulary
- Pharmacy directory
- Prior authorization forms

Please visit the Texas Medicaid/CHIP Vendor Drug Program's:

- Preferred Drug List
- Medicaid formulary

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# Healthcare Effectiveness Data Information Set (HEDIS)

# Measures and Data Collection

HEDIS® is a measurement tool coordinated and administered by the National Committee for Quality Assurance (NCQA) used by more than 90% of America's Health Plans.

The results are used to:

- Measure performance
- Identify quality initiatives
- Provide educational programs for Providers and Members

Measures are specifically defined so that the performance of all health plans can be measured equally. Measures can change from year to year.

# HEDIS Education & Questions

For more in depth information on HEDIS® including billing codes, diagnoses, etc. visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select HEDIS®.

You may also visit our Quality Improvement page for additional HEDIS® information.

For HEDIS® Questions contact:

Tonia Bridges, BSN, RN
Director, Quality Improvement
Cook Children's Health Plan
Phone: 682-303-2129
Fax: 682-885-8494
Email: Tonia.Bridges@cookchildrens.org

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# Health Insurance Portability and Accountability Act (HIPAA)

# HIPAA

As a Medicaid Provider and covered entity, you will be required to comply with HIPAA EDI (Electronic Data Interchange) and Privacy Regulations.

HIPAA regulations apply to:

- Health Plans
- Health Care Clearinghouses
- Health Care Providers

The legislation carries heavy civil and criminal penalties for failure to comply:

- Civil penalties may include penalties from $100 per violation to $25,000 per calendar year
- Criminal penalties may include up to ten (10) years imprisonment and a $250,000 fine

# Early Childhood Intervention

# Early Childhood Intervention

Early Childhood Intervention (ECI) is a statewide program with the Texas Health and Human Services Commission for families with children birth up to age three (3), with developmental delays, disabilities, or certain medical diagnoses that may impact development.

All health-care professionals are required by federal and state regulations to refer children who are birth through thirty-five (35) months of age to the Texas Health and Human Services (HHS) ECI program as soon as possible, but no longer than seven (7) days after identifying a disability or suspected delay in development.

# Early Childhood Intervention

- Eligibility
  - Children birth through thirty-five (35) months of age
  - Must have one of the following:
    - Medically Diagnosed Condition
    - Auditory or Visual impairment
    - Developmental Delay
- Referral
  - ECI Referral Form
  - Early Childhood Intervention Care Line 888-754-0524
  - Cook Children's Health Plan Care Management Department 800-862-2246
  - A medical diagnosis or a confirmed developmental delay is not needed to refer

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# Early Childhood Intervention

- Additional Information
  - HHS ECI website

# Cultural Competency

# Cultural Competency

Cook Children's Health Plan is committed to ensuring that our staff and Providers are informed of the importance of providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Our Members may have a limited proficiency with the English language, disabilities that may impede their ability to communicate with the health plan and Providers as well as Members that come from other cultures that view health care services differently than other Members.

Our primary goal is to deliver health services in a sensitive and compassionate manner to the population in our service area and assist Members with increased access, coordinated care, and improved health outcomes.

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# Provider Training Link

Please use the link provided to access educational material for Health Care Providers.

- Culturally Effective Healthcare
  - You will be required to create an account and will receive a certificate of completion

Submit your certificates to:

- CCHPNetworkDevelopment@cookchildrens.org.
- You will be reflected in the Cook Children's Health Plan Provider Directory as completing Cultural Competency Training

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# Cultural Competency

For a more in depth training and to receive continuing education hours visit cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Cultural Competency Training.

# Fraud, Waste and Abuse

# What is Fraud, Waste and Abuse?

Fraud:

- Fraud is an **intentional** deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

Waste:

- Waste includes any practice that a reasonably prudent person would deem **careless** or that would allow **inefficient** use of resources, items, or service

Abuse:

- Abuse means provider practices that are **inconsistent with sound fiscal, business, or medical practices** and result in an **unnecessary cost** to Medicaid, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes client practices that result in unnecessary cost to Medicaid

Cook Children's Health Plan

# Fraud, Waste and Abuse

For in depth information on Fraud, Waste and Abuse visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Fraud, Waste and Abuse.

# Abuse, Neglect and Exploitation

# What is ANE?

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

# What is ANE?

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 thirty-three (33) identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the person

# Abuse, Neglect and Exploitation

For in depth information on Abuse, Neglect and Exploitation visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Abuse, Neglect and Exploitation.

# 1915 (c) Waiver Program Providers

The Health and Human Services Commission (HHSC) will implement a new a statewide critical incident management system (CIMS) for reporting critical incidents.

Note: All 1915 (c) waiver program Providers will be required to report information into the new system.

HHSC is working with FEI Systems, the CIMS vendor, to configure a platform to collect all required critical incident information across all 1915 (c) waiver programs.

- This will include information on abuse, neglect and exploitation allegations in addition to other critical incidents required by program policy
- The system is targeted to go live June 6, 2022

Questions can be submitted to: LTSS_Policy@hhs.texas.gov

Cook Children's Health Plan

# Population Health

# What is Population Health?

Population Health is a focus on the health outcomes of groups of people with similar needs or issues that affect their health.

For in depth information on Population Health visit our website cookchp.org, select Providers, Provider Relations, scroll down to Training Presentations and select Population Health.

# Referrals

There are three (3) ways a Provider can initiate a referral to STAR/CHIP Care Management and Population Health/Disease Management.

- If you have access to the Secure Provider Portal, we ask that you complete the referral by submitting a Customer Service Request
  - Log in to the Secure Provider Portal, from the homepage click Customer Service, select the topic: Link-Referral to STAR/CHIP Care Management and Population
- Cook Children's Health System Providers can submit the referral through EPIC via the In Basket to CCHP CM Management
- Providers may also send an email to CCHPStarChipCM@cookchildrens.org

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# Member Rights and Responsibilities

Cook Children's Health Plan

# Member Rights & Responsibilities

Members and Providers can view Member Rights and Responsibilities at cookchp.org, select Members, and the product (STAR, STAR Kids, and CHIP) you wish to review.

# Member Self Referrals

Members can self-refer for the following services:

- Female Members have the right to pick an OB/GYN
  - Whether that doctor is in the same network as the Member's Primary Care Provider or not
  - Out of network must be coordinated with the health plan
  - Members with twelve (12) weeks or less remaining may stay with current OB/GYN through post-partum care
- Behavioral Health Services
  - Members can use their PCP as long as it is within their scope
  - Members may call the Behavioral Health Provider indicated on the Member's ID card
- Vision
  - Network Ophthalmologist or Therapeutic Optometrist
  - Self-referral benefit – routine vision examination

# Member Self Referrals

- Dental
  - Members can self-refer by contacting their Dental Plan Provider
    - DentaQuest: 800-516-0165
    - MCNA Dental: 800-494-6262
    - United Healthcare Dental: 800-822-5353
- Emergency Services

# Reference Pages

# Reference Page

**Cook Children's Health Plan Website**
cookchp.org

**Secure Provider Portal**
https://epiccarelink.cookchp.org/LinkHealthPlan/common/epic_login.asp

**Provider Forms & Manuals**
Provider Manual and Forms | Cook Children's Health Plan (cookchp.org)

**Verisys**
Provider Data Management Transformed | Verisys

**TMHP Website**
https://www.tmhp.com/

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# Reference Page

**Complaints and Appeals**
Complaints and Appeals | Cook Children's Health Plan (cookchp.org)

**Electronic Submission Services**
Electronic Claims Submission | Cook Children's Health Plan (cookchp.org)

**Education & Training**
Provider Relations | Cook Children's Health Plan (cookchp.org)

**Texas Health Steps**
https://cookchp.org/providers/Pages/texas-health-steps.aspx

**Texas Health Steps Provider Outreach Referral Form**
http://dshs.texas.gov/thsteps/Texas-Health-Steps-Provider-Outreach-Referral-Service-Referral-Form-Instructions.shtm

Cook Children's Health Plan

# Reference Page

**Prior Authorization Search**
Prior Authorization Search | Cook Children's Health Plan (cookchp.org)

**Quality Improvement**
Quality Improvement | Cook Children's Health Plan (cookchp.org)

**Beacon Health Options**
Behavioral Health Services | Cook Children's Health Plan (cookchp.org)

**Navitus**
Provider Pharmacy Information | Cook Children's Health Plan (cookchp.org)

**Medicaid Provider Enrollment** (Texas Medicaid and Healthcare Partnership)
http://www.tmhp.com/Pages/default.aspx

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# Reference Page

**Access2Care**
https://cookchp.org/SiteCollectionDocuments/pdfs/provider-news/Non-Emergency-Medical-Transportation-Services-Access2Care-Flyer.pdf

**Cultural Competency Training**
https://cookchp.org/providers/Pages/provider-relations.aspx

**Provider News**
Provider News | Cook Children's Health Plan (cookchp.org)

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