dell children's Health Plan

Travis service area—Bastrop, Burnet, Caldwell, Hays, Lee, Fayette, Travis and Williamson counties.

Provider Manual

STAR and CHIP

1-844-781-2343 (TTY 7-1-1)
DellChildrensHealthPlan.com

September 2026 | PR-0626-011

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

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Chapter 1: **Introduction and objectives**

Introduction

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

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

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network.

Dell Children's Health Plan retains the right to add to, delete from and otherwise modify this provider manual. Material in this provider manual is subject to change. Please visit DellChildrensHealthPlan.com for the most up-to-date information.

The provider shall comply with the terms of the Provider Manual and all applicable Health Plan policies and procedures when providing and seeking reimbursement for Covered Services. The Health Plan's Provider Manual and all amendments to the Provider Manual are hereby incorporated by reference into the Agreement.

Program objectives

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

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

The Children's Health Insurance Program (CHIP) provides health coverage for children age 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private health care coverage. A child must be age 18 or younger, a Texas resident, a U.S. citizen or legal permanent resident and meet all income and resource guidelines.

Objectives of the CHIP program are to:

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

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

Non-discrimination statement

Dell Children's Health Plan does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Dell Children's Health Plan does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Dell Children's Health Plan does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Dell Children's Health Plan may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Dell Children's Health Plan provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Dell Children's Health Plan representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: HHSC Civil Rights Office
  701 W. 51st Street
  Mail Code W206
  Austin, Texas 78751
- By phone at: **Toll Free (888) 388-6332 or (512) 438-4313 (TTY: (877) 432-7232**
- By fax: **(512) 438-58851**

Dell Children's Health Plan provides free tools and services to people with disabilities to communicate effectively with us. Dell Children's Health Plan also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the member services number on their member ID card.

If you or your patient believe that Dell Children's Health Plan has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Mail: **Dell Children's Health Plan**
  Attn: Member Advocacy Specialist
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- Phone: **1-855-921-6284 (TTY 7-1-1), and ask for a member advocate**

Equal program access on the basis of gender

Dell Children's Health Plan provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Dell Children's Health Plan must also treat individuals consistently with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, gender, gender identity, age or disability).

Dell Children's Health Plan may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Chapter 2: **Quick reference information**

Quick reference topic	Description
Provider inquiry line	**1-844-781-2343 (TTY 7-1-1)**
Dell Children's Health Plan website	DellChildrensHealthPlan.com This site features tools for real-time eligibility inquiry, claims submission/status/appeals and prior authorization requests/status/appeals. In addition, the site offers general information and various tools that are helpful to the provider such as: • Preferred drug list • List of drugs requiring prior authorization • Provider manuals • Referral directories • Provider newsletters • Prior authorization list • Credentialing and recredentialing information • Electronic remittance advice and electronic funds transfer information • Electronic Visit Verification information • Case management support • Quality improvement information • Texas Health Steps • Cultural Competency • Children of migrant farm workers • Health plan and industry updates • Clinical practice guidelines • Downloadable forms • Available provider trainings • FAQs

Quick reference topic	Description
Notification/prior authorization	May be submitted as indicated below: • Provider portal: **secure.healthx.com/Provider_2022** • Fax: **512-324-3014/1-844-981-3329** • Phone: **1-855-962-4453 (TTY 7-1-1)** Non-emergency medical transportation (other than ambulance) Phone: **1-844-867-2742 (TTY 7-1-1** (MTM Health) Data required for notification/prior authorization includes: • Member ID number • Legible name of referring provider and NPI • Legible name of individual referred to provider and NPI • Number of visits/services • Date(s) of service • Diagnosis • CPT/HCPCS code • Copy of physician's order for services by ancillary providers
National Provider Identifier (NPI)	National Provider Identifier (NPI)—The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard, unique provider identifier for health care providers. All participating providers must have an NPI number. The NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers such as the states in which they practice or their specialties. For more information about the NPI and the application process, visit **nppes.cms.hhs.gov.** You can complete the application online (estimated time to complete the NPI application is 20 minutes), complete a paper application by downloading one online or calling **1-800-465-3203** to request an application.

Quick reference topic	Description
Claims information	Dell Children's Health Plan uses Smart Data Solutions (SDS) for electronic claims submissions. Electronic claims payor ID **38261** Submit paper claims to: **Dell Children's Health Plan** **PO Box 37502** **Oak Park, MI** **48237-0502** Timely filing is within 95 days from the date of service or per the terms of the provider agreement. We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior authorization status. Visit secure.healthx.com/Provider_2022 to access this resource. If you are unable to access the internet, you may receive claims, eligibility and prior authorization status over the telephone by calling our provider inquiry line at **1-844-781-2343**.
Medical appeal information	Medical appeals can be initiated by the member or the provider on behalf of the member with the member's signed consent. They must be submitted within 60 calendar days from receipt of an adverse determination for STAR and for CHIP, 180 days from the date of decision. Signed consent is not required for CHIP members. Be sure to include medical charts or other supporting information. Members may send a written request for appeal to the address below, or they can call Member Services at **1-855-921-6284 (TTY 7-1-1)** to request an appeal: **Dell Children's Health Plan** **Medical Management—Appeals Team** **1345 Philomena St., Ste. 305** **Austin, TX 78723**
Payment appeals	A provider has 120 days from the date of the original explanation of payment (EOP) to file a payment appeal. Mail to: **Dell Children's Health Plan** **PO Box 37502** **Oak Park, MI** **48237-0502** Providers can also utilize the online payment appeal tool at secure.healthx.com/Provider_2022.

Quick reference topic	Description
Complaints	Provider complaints can be faxed to **512-855-4909** or mailed to: **Dell Children's Health Plan** **ATTN: Complaints** **PO Box 37502** **Oak Park, MI** **48237-0502** Providers can also email complaints to **DCHPcomplaints@ascension.org.**
Service Coordination	Refer members for service coordination in one of three ways: • Calling Service Coordination at **512-324-3015 (TTY 7-1-1) or 1-844-964-3015 (TTY 7-1-1)** • Faxing a completed Service Coordination Referral Form to **512-324-3016** • Email: **dchp-CM@ascension.org**
Interpreter services	• Telephonic services for those who are deaf or hard of hearing: **7-1-1** • Over-the-phone interpreter services: Health plan clinical services teams, advocates and our in-network providers can access over-the-phone interpreter services on-demand via Language Line. You may access these services for Dell Children's Health Plan members by calling the toll-free number **1-833-994-3567.** • Face-to-face interpreter services: Dell Children's Health Plan is contracted with Akorbi Services to provide face-to-face interpreter services for our members during medical appointments. Requesting services: Call Provider Customer Service at **1-844-781-2343** • For Onsite in person: 72-hour notice prior to when the interpreter will be needed, however Akorbi can accommodate less than 72-hour requests should you have a last-minute need. • For Sign Language: 2 week notice prior to when the interpreter will be needed and that is based on the high demand and resource availability with ASL, however Akorbi can accommodate lesser 2 week notice
Behavioral health services	**1-800-424-1764**

Quick reference topic	Description
Dental services	Members under age 21 receive dental services through one of the dental maintenance organizations listed below: • DentaQuest: **1-800-508-6775 (CHIP**), **1-800-516-0165 (Medicaid)** • MCNA Dental: **1-800-494-6262** • United Healthcare Dental: **1-877-901-7321**
24-Hour Nurse HelpLine	**1-855-712-6700 (TTY 7-1-1)**
Dell Children's Health Plan Member Services	**1-855-921-6284 (TTY 7-1-1)**
Pharmacy services (Navitus)	Pharmacy prior authorization Fax: **1-855-668-8553** Phone: **1-877-908-6023** Website: navitus.com
Vision services (Superior Vision of Texas)	• Member Services Number **1-800-879-6901** • Provider Services Number **1-877-235-5317**
Electronic Data Interchange (EDI) Smart Data Solutions	**1-855-297-4436** or stream.support@sdata.us
Ascension provider portal (claim status inquiries, member eligibility and benefits information, submit reconsiderations, appeals, and overpayment disputes, and prior authorization)	secure.healthx.com/Provider_2022
Enrollment/disenrollment Medicaid and CHIP	**1-800-964-2777**
Medical Transportation Program (MTP)	**1-877-633-8747**
MTM Health (non-emergent transportation other than ambulance when MTP is not available)	**1-844-867-2742**
Texas Health Steps Program	**1-877-847-8377**
Vendor Drug Program (VDP)	txvendordrug.com

Chapter 3: **Provider roles**

Role of the primary care provider or medical home

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

Role of the specialty care provider

Dell Children's Health Plan has established a network of specialty care providers to provide health care services for those members in need of specialty care. Network referrals from the PCP are not required for in-network specialists. For more information on prior authorization, refer to the utilization management chapter in this manual and the preauthorization lookup tool on our provider website at **DellChildrensHealthPlan.com**.

The specialty care provider coordinates care with the member's PCP and is responsible for obtaining prior authorization for services that require authorization prior to rendering the service. Services requested or provided must be within the member's plan as a covered benefit. Our service coordinators are available to assist specialty providers with the management of catastrophic, chronic or problem cases.

Role of the CHIP Perinatal provider

CHIP Perinatal program benefits are limited to services that affect the health of the unborn child. Expectant mothers enrolled in the CHIP Perinatal program will not have an assigned PCP on their ID card. CHIP Perinate members (pregnant women) can go to any CHIP Perinatal provider listed on the Dell Children's Health Plan provider list for prenatal and postpartum care. Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client's child may be eligible under the CHIP.

Role of the pharmacy

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

the Vendor Drug Program (VDP) website at **txvendordrug.com**. Dell Children's Health Plan and Navitus network providers can also access the formulary and PDL at this site.

Role of the main dental home

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

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

Network limitations

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

Chapter 4: **STAR covered services**

Texas Health Steps services

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

Resource	Link
Texas Medicaid Provider Procedures Manual	tmhp.com/resources/provider-manuals/tmppm
Texas Health Steps website	hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/texas-health-steps
Texas Health Steps Provider Relations contact website	txhealthsteps.com/provider-relations-representatives-resources
Texas Health Steps Training Website	txhealthsteps.com

Information includes the following:

- Periodicity schedule
- State and federally mandated elements of the Texas Health Steps exam
- State provider enrollment requirements and TPI requirements
- Dental varnish provider participation requirements
- Advisory Committee on Immunization Practice (ACIP) immunization schedule
- Vaccines for Children (VFC) program description
- ImmTrac (immunization registry)
- Submission of all laboratory specimens (collected as a required component of a Texas Health Steps checkup to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis)

- Referrals
- Comprehensive care program services, including private duty nursing, prescribed pediatric extended care centers and therapies

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

Prescribed pediatric extended care centers (PPECCs) and private duty nursing (PDN)

A member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A member may receive both on the same day, but not both simultaneously (e.g., PDN may be provided before or after PPECC services are provided). The combined total hours between PDN and PPECC services are limited to no more than 12 hours in a 24-hour period and are not anticipated to increase unless there is a change in the client's medical condition or the authorized hours are not commensurate with the member's medical needs. PPECC services may also not be provided overnight. Per 1 TAC §363.209(c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

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

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

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

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

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

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

Documentation of completed Texas Health Steps components and elements

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

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

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

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 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. Comprehensive unclothed physical examination which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure and vision and hearing screening
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. Immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening provider is responsible for administration of the immunization and is 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 (ImmTrac2).
- Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit **dshs.texas.gov/immunizations**.

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

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

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

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

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

For foster care situations, Texas Health Steps requires that an initial Texas Health Steps checkup must occur within 30 Days of entry into conservatorship.

Children of migrant farmworkers

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

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under

the periodicity schedule is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

Contact our Provider Relations department at **1-512-324-3125 (TTY 7-1-1)** to report any health plan members that you identify as children of migrant farmworkers.

Telemedicine, telehealth and telemonitoring access

We encourage our network providers to offer telemedicine, telehealth and telemonitoring capabilities to our members. Information will be included in our provider directories as to which providers have these services available. Compliance for Telemedicine, telehealth and telemonitoring access is outlined in Texas Government Code §531.0216, §§531.02161(a), (c) and (d), Texas Health and Safety Code §62.1571, and Tex. Gov't Code §531.02161.

CHIP Covered Services may be delivered by Telemedicine and Telehealth.

School-based telemedicine medical services are a covered service for members in a primary or secondary school-based setting. We will reimburse an eligible distant site physician providing treatment even if the physician is not the member's Primary Care Physician or provider, or is an out-of-network provider. Prior authorization is not required for school-based telemedicine medical services. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code §531.0217 (c-4).

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

Ambulance transportation services

Emergent

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

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

Non-emergent

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

A physician, nursing facility, health care provider or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed, submitted via the provider portal at secure.healthx.com/Provider_2022 or called in via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by non-emergent ambulance transportation. The ambulance provider may not submit an authorization request.

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

Some requests for non-emergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day. The request can be called in or faxed the next business day to the numbers listed in the table below.

Request type	Behavioral health (BH) facilities or to a behavioral health provider	All other members for discharge from facility to home or from home to a provider/facility
Urgent same day	**1-800-424-1764 (TTY-7-1-1)**	**1-855-962-4453 (TTY-7-1-1)**
Non Urgent requests	**Fax request to 1-866-877-5229**	Fax request to **512-324-3014/1-844-981-3329**

Non-emergency medical transportation (NEMT) services

What are NEMT services and MTM Health?

Transportation to covered health care services is available for Medicaid members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy and other places an individual receives Medicaid services. The transportation benefit does NOT include ambulance trips.

What services are available for non-emergency medical appointments?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus
- Commercial airline transportation services for long distance travel approved by the Health Plan for members under 20 years of age or younger with medical necessity
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the member, the member's family member, friend or neighbor
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long

distance trip to obtain a covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant. If travel exceeds more than four hours for the appointment, the transportation vendor will provide meals for the approved members/attendant

- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service or laundry service. The transportation vendor's guidelines state that:
    - If the member needs to leave their home before 5:00 a.m. the day of their appointment in order to make it to their appointment on time, travel will be arranged for the day before the appointment which means the member will also receive meals and lodging the night before the appointment.
    - If the member arrives back home after 9:00 p.m. the day of their appointment, travel will be arranged for the day after the member's appointment which means the member will receive lodging the night of their appointment date, as well as meals the day after their appointment when they will be traveling.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services if they state they can not provide the funds themselves in advance
- If you have a member needing assistance while traveling to and from his or her appointment, the transportation vendor will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian or other authorized adult or have consent from a parent, guardian or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature regardless of the member's age.

Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. 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.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. 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.

If you have a member you think would benefit from receiving NEMT services, please refer him or her to our transportation vendor at **1-844-867-2742** for more information.

Dental services

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

Medicaid non-emergency dental services

Dell Children's Health Plan is not responsible for paying for routine dental services provided to Medicaid members. These services are paid through dental managed care organizations.

Dell Children's Health Plan is responsible for paying for treatment and devices for craniofacial anomalies and for oral evaluation and fluoride varnish benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 months through 35 months old.

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

- The OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance and assistance with a main dental home choice.
- An OEFV (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home.
- OEFV must be billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup (99381, 99382, 99391 or 99392 medical checkup procedure code) and is limited to six services per lifetime by any provider.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier and diagnosis code Z00.121 or Z00.129 for an intermediate oral evaluation with fluoride varnish application.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a main dental home and document the member's main dental home choice in the member's file.
- There is no additional reimbursement for OEFV services for FQHCs.

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

CHIP non-emergency dental services

Dell Children's Health Plan is not responsible for paying for routine dental services provided to CHIP

and CHIP Perinatal members. These services are paid through dental managed care organizations. Dell Children's Health Plan is responsible for paying for treatment and devices for craniofacial anomalies.

CHIP emergency dental services

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

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

Vision services

Coverage for STAR members may be obtained by calling Superior Vision of Texas at **1-877-235-5317**. Services are available for member self-referral to a network vision provider for basic vision benefits. Members can also call **1-800-879-6901**.

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

STAR managed care covered services

Dell Children's Health Plan will provide STAR members a benefit package that includes fee-for-service (FFS) services currently covered under the Medicaid program. Please refer to the current Texas Medicaid Provider Procedures Manual for a listing of limitations and exclusions at **tmhp.com**.

Covered benefits include, but are not limited to, the medically necessary services below:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral health services*, including:
    - Inpatient mental health services for adults and children (birth through age 20)

        - services may be provided in a freestanding psychiatric hospital in lieu of an acute care inpatient setting
    - Acute inpatient mental health services for adults
    - Outpatient mental health services
    - Psychiatry services
    - Mental health rehabilitative services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication-assisted therapy
    - Medication-assisted therapy
    - Applied Behavior Analysis (ABA) therapy
    - Residential substance use disorder treatment services including:
        - Detoxification services
        - Substance use disorder treatment (including room and board)
- Birthing services provided by a provider or certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC
- Hospital services, including inpatient and outpatient (the $200,000 limit on inpatient services and spell-of-illness limitation does not apply to STAR members)
- Laboratory
- Mastectomy, breast reconstruction and related follow-up procedures, including
    - Inpatient and outpatient services provided for 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; surgery and reconstruction on the other breast to produce symmetrical appearance
- Medical checkups and Comprehensive Care Program (CCP) services for children (birth through age 20) through the Texas Health Steps Program including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Nonemergency Medical Transportation Services, including:
    - Demand response transportation services, including Nonmedical Transportation prearranged rides, shared rides, and public transportation services;
    - Mass transit;
    - Individual transportation participant mileage reimbursement;
    - Meals;
    - Lodging;
    - Advanced funds; and
- Commercial airline transportation services, including out of state travel.
- Mental health targeted case management
- Mental Health Rehabilitative Services
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals (unlimited prescriptions for adults are only available for those members not covered by Medicare)
- 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

- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging and X-rays
- Specialty physician services
- Telemonitoring to the extent covered by Texas Government Code §531.01276
- Telemedicine and Telehealth modalities for the delivery of covered services
- Therapies (physical, occupational and speech)
- Transplantation of organs and tissues
- Vision (Note: Includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)

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

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.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
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.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover 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.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR Health	STAR Health	STAR Health	STAR Health covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP 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.

Chapter 5: **Coordination with non-Medicaid managed care covered services for STAR members**

Overview

There are other services not covered through Dell Children's Health Plan that may be available to STAR members through other state programs. Dell Children's Health Plan providers should make every effort to coordinate with these resources in order to maximize the STAR member's benefits.

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

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School, Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Texas Health Steps personal care services for members birth through age 20
- Health and Human Services Commission (HHSC) hospice services
- Admission to inpatient mental health facilities as a condition of probation

All participating providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Chapter 6: **CHIP and CHIP Perinatal covered services**

CHIP covered services

CHIP services must meet the CHIP definition of medically necessary covered services to be covered. The services supporting Members with ongoing or chronic conditions must be authorized in a manner that reflects the Member's ongoing need for such services and supports. There is no lifetime maximum on benefits; however, the 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Copays for certain services apply until a family reaches its specific cost sharing maximum.

CHIP Perinatal covered services

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

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

If born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker, a CHIP Perinate Newborn will maintain their coverage through his or her CHIP Perinatal health plan. CHIP Perinate Newborns have the same benefits as CHIP members, as shown in the table below.

A CHIP Perinate (unborn child) member who lives in a family with an income at or below the Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and will be placed in FFS effective on the date of birth after the birth is reported to HHSC's enrollment broker. Managed care enrollment will occur prospectively after an enrollment packet is mailed to the household and they are given the opportunity to select an MCO of their choice. If no selection is made, HHSC will assign an MCO using the current default plan assignment.

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

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

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary ◦ ICU and services • Member 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, including biomarker testing, and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non viable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C procedures; • appropriate provider administered medications; • Ultrasounds, and • Histological examination of tissue samples

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	• 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. • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical	

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	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	
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) And Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component • Laboratory, including biomarker testing, 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	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 (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;

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	• 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-administeredmedications; ◦ 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 or 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	◦ Ultrasounds, and ◦ Histological examination of tissue samples (1) 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. (2) 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. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32- 36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical 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	
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, including biomarker testing, services 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	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

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	◦ Administration of anesthesia by physician (other than surgeon) or CRNA ◦ Second surgical opinions ◦ Same-day surgery performed in a hospital without an overnight stay ◦ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician performed technical and interpretive components) • Physician and professional services for 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 cesarean section under inpatient, outpatient and physician services. • 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	◦ 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

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	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	
Birthing Center Services	Covers services rendered to a newborn immediately following delivery. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP Members.	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).

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
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. Primary and preventive health benefits do not include pre pregnancy family reproductive services and supplies or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; One (1) visit every two to three (2-3) weeks from 28 to 36 weeks of pregnancy; and One (1) visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)

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

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

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN or LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
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 Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapter D ◦ or	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	◦ 2) 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 PCP 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 Texas Health and Safety Code Chapters 573 Subchapters B and C, or 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D: ◦ or ◦ 2)as a condition of probation	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
	• The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2. • A Qualified Mental Health Provider Community Services (QMHP-CSs). Services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral	
Inpatient Substance Use Disorder Treatment Services	Services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • When inpatient and residential substance use disorder treatment services are required as: ◦ 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or ◦ 2) 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 PCP referral	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
Outpatient Substance Use Disorder Treatment Services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 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 outpatient substance use disorder treatment services are required as: ◦ 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code;, or ◦ 2) 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 PCP referral	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
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	Not a covered benefit.
Hospice Care Services	Services include but are not limited to: • Palliative care including medical and support services for those children who have six months or less to live to keep patients comfortable during the last weeks and months before death • Treatment services including treatment related to the terminal illness • Up to a maximum of 120 days with a six-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
Emergency Services, Including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions labor and delivery. Covered services include but are not limited to the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removal of cysts of cysts and treatment relating to oral abscess of tooth or gum origin.	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child • Stabilization services related to the labor with delivery of the covered unborn child • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) is a covered benefit Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include but are not limited to the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses	Not a covered benefit.
Vision benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.

Covered benefit	CHIP and CHIP Perinate newborn member	CHIP Perinate members (unborn child)
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program • Health plan defines plan approved program • May be subject to formulary requirements	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy dispensed and provider administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.

CHIP member prescriptions

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

Coordination with non-CHIP covered services

There are other services not covered through Dell Children's Health Plan; however, the services are available to CHIP members through other state programs. Dell Children's Health Plan providers should make every effort to coordinate with these resources in order to maximize the CHIP member's benefits. Providers must coordinate with Texas Agency Administered Programs, Case Management Services and Essential Health Services for:

- Dental services
- Texas agency-administered programs and case management services

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

All participating providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Dell Children's Health Plan Member Services at **1-855-921-6284 (TTY 7-1-1)**.

Value-added services—all products

We cover extra health care benefits for our members. These extra benefits are also called value-added services. You can find a list of these benefits in our member handbooks or on our website at **dellchildrenshealthplan.com/for-members/value-added-services.** If you have problems accessing the information, please call Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Chapter 7: **Behavioral health for STAR and CHIP members**

Overview

Behavioral health services are covered services for the treatment of mental, emotional or chemical dependency disorders. We provide coverage of medically necessary behavioral health services as indicated below:

1. Texas Health Steps behavioral health services for Medicaid members birth through age 20 that are necessary to correct or ameliorate a mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a mental illness or condition may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) below.
2. For Medicaid members over age 20 and CHIP members, behavioral health-related health care 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

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services, providers should call **1-844-781-2343 (TTY 7-1-1)** and members should call **1-855-921-6284 (TTY 7-1-1)**.

Behavioral health covered services

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

- Inpatient mental health services (services may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient setting)
- Outpatient mental health services
- Applied Behavior Analysis (ABA) therapy
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy
- Residential substance use disorder treatment services, including detoxification services and room and board
- Mental health rehabilitative services
- Mental health targeted case management

CHIP covered* behavioral health services include:

- Inpatient mental health
- Outpatient mental health
- Inpatient substance use disorder
- Outpatient substance use disorder

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

Mental health rehabilitative services and mental health targeted case management

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

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

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping or employment) due to the disorder

- Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services

Severe emotional disturbance (SED) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

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

MHR services include training and services that help the member maintain independence in the home and community, such as:

- Medication training and support—curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction, and the increased tenure in the community
- Psychosocial rehabilitative services—social, educational, vocational, behavioral or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development—skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors and other skills necessary for independent living or, when age-appropriate, functioning effectively with family, peers and teachers
- Crisis intervention—intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting
- Day program for acute needs—short-term intensive and site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting, or reduce the amount of time spent in the more restrictive setting

Mental health targeted case management (TCM) means services designed to assist members with gaining access to needed medical, social, educational and other services and supports.
TCM services include:

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

MHR and TCM services, including any limitations to these services, are described in the most current TMPPM, including the Behavioral Health, Rehabilitation and Case Management Services Handbook.
We will authorize these services using the Department of State Health Services (DSHS) Resiliency and

Recovery Utilization Management Guidelines (RRUMG), but Dell Children's Health Plan is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at: **hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf.**

Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found: **hhs.texas.gov/sites/default/files/documents/trr-um-guidelines-child.pdf**.

Providers of MHR and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tools to assess a member's need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Dell Children's Health Plan by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. A provider entity must attest to us that the organization has the ability to provide, either directly or through subcontract, the full array of RRUMG services to members.

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

Attention deficit hyperactivity disorder (ADHD)

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the provider agreement. Covered benefits are as outlined in the TMPPM.

Primary and specialty services

Members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members furnished by the ordering provider at a lab located at or near the provider's office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments

Behavioral health care provider responsibilities

We maintain a behavioral health provider network that includes psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area. Our members can

self-refer to a participating behavioral health provider by calling Member Services at **1-800-424-1764 (TTY 7-1-1)**.

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

We will review prescribing patterns for psychotropic medications. For treatment of adults, we will base our parameters on a peer-reviewed industry standard such as the DSHS Psychotropic Drug Formulary at **www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/psychiatric/psychiatric-drug-formulary.pdf.** For treatment of children, all providers must utilize the Psychotropic Medication Utilization Parameters for Foster Children found at **hhs.texas.gov/sites/default/files/documents/update-psychotropic-medications-children-texas-foster-care-2026.pdf.**

Providers who furnish routine outpatient behavioral health services must schedule initial appointments within the earlier of 10 business days or 14 calendar days of a request. Routine care after the initial visit must be scheduled within three weeks of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Primary care providers should:

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

Primary care providers can offer behavioral health services when:

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

Behavioral health providers must:

- Refer members with known or suspected physical health problems or disorders to the primary care provider for examination and treatment

- Utilize the most current DSM multi-axial classification when assessing members; the Health and Human Services Commission (HHSC) may require the use of other assessment instruments/outcome measures in addition to the DSM; network providers must document DSM and assessment/outcome information in the member's medical record
- Send initial and quarterly summary reports of a member's behavioral health status to the primary care provider with the member's consent
- Be licensed for physical health services if they are provided

Care continuity and coordination guidelines

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

Our care continuity and coordination guidelines for primary care providers and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable
- Completing and sending the member's consent for information release to the collaborating provider
- Using the release as necessary for the administration and provision of care
- Noting contacts and collaboration in the member's chart
- Responding to requests for collaboration within one week, or immediately if an emergency is indicated
- Sending a copy of a completed Coordination of Care/Treatment Summary Form to us and the member's primary care provider when the member has seen a behavioral health provider. The form can be found on our website at **DellChildrensHealthPlan.com.**
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's primary care provider
- Contacting the primary care provider when a behavioral health provider changes the behavioral health treatment plan
- Contacting the behavioral health provider when the primary care provider determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the coordination of care and treatment summary

Emergency and urgent behavioral health services

Emergency behavioral health services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. And in an emergency and without immediate intervention and/or medical attention, the member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 9-1-1 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug dependent with signs of severe withdrawal

We do not require prior authorization or notification of emergency services, including emergency room and ambulance services.

Urgent behavioral health services

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to him or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

Prior authorization and referrals for behavioral health

Members may self-refer to any Dell Children's Health Plan network behavioral health services provider by calling Member Services at **1-800-424-1764 (TTY 7-1-1)**. No prior authorization or referral is required from the PCP.

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

- Calling Provider Services at **1-844-781-2343 (TTY 7-1-1)**

- Faxing information to our behavioral health fax line at **(866) 354-8758** for all services.
- Visiting the **Magellan provider portal**.

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

Court-ordered commitment

We provide benefits for Medicaid- and CHIP-covered inpatient and outpatient psychiatric services to members birth through age 20 and ages 65 and over who have been ordered to receive the services by a court of competent jurisdiction, including services ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation.

We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.

Dell Children's Health Plan will:

- Not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service for members age 20 and younger or ages 65 and older; any modification or termination of services will be presented to the court with jurisdiction over the matter for determination.
- Comply with the utilization review of chemical dependency treatment; chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.
- Not allow members ordered to receive treatment under a court-ordered commitment to appeal the commitment through our complaint or appeals processes.

Chapter 8: **Quality management**

Overview

We maintain a comprehensive Quality Management (QM) program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to both providers and members upon request. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program. If you would like more information about our Quality Management program goals, processes and outcomes, call Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

The initial program development was based on a review of the needs of the population served and HHSC requirements. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age and gender distribution but also a review of utilization data—inpatient, emergent and urgent care, and office visits by type and volume. This information is used to define high volume or areas of high utilization and preventable events. HEDIS® performance is evaluated annually and compared against regional and national Medicaid benchmarks. Performance is analyzed for barriers and best practices, and interventions are developed to improve performance.

We maintain a quality committee structure that includes a Quality Improvement Committee (QIC), provider advisory committee (PAC), a medical advisory committee (MAC) and a credentialing committee (with participation from network physicians and practitioners), which also serves as a peer review committee.
These committees report into the Quality Management committee structure which reports to the plan board.

Note: All providers must allow Dell Children's Health Plan to use performance data in cooperation with our Quality Improvement program and activities.

Quality Improvement Committee overview

The Quality Improvement Committee (QIC) provides a forum for interdepartmental members of the committee to engage in review, coordination and direction of the Medicaid Quality Management program. It oversees the credentialing and peer review committee, which provides a systematic approach for monitoring the quality and appropriateness of care. Additionally, the QIC provides approval recommendations for activities relating to key processes, clinical guidelines, and Medicaid-specific policies and procedures. The QIC's responsibilities are to:

- Implement the Quality Improvement program and the work plan
- Lead and provide oversight of the development and continuous monitoring of our quality improvement and utilization management programs and work plans, based on demographics and epidemiologic

characteristics

- Promote and support the achievement of high-quality care delivery, ensure compliance with all regulatory standards, and assess all activities against Dell Children's Health Plan and state and federal regulations
- Collaborate and coordinate with subcommittees regarding quality improvement efforts
- Maintain oversight of all delegated functions, the credentialing and recredentialing processes, the peer review process and utilization management and clinical support activities (e.g., service coordination and disease management)
- Consider and/or act in regard to physician sanctions
- Approve recommendations from the credentialing committee to credential or recredential providers
- Review and provide input towards policies and procedures for credentialing and recredentialing, clinically oriented Quality Management, Utilization Management and disease/service coordination

Purpose

The purpose of the quality improvement committee (QIC) is to maintain quality as a cornerstone of our culture. The committee serves as an instrument of change through demonstrable improvement in care and service. The QIC's purpose is:

- Establish strategic direction, monitor and support implementation of the Quality Management program.
- Establish processes and structure that ensures accreditation compliance
- Recommend policy decisions through the review and approval of Texas policies and by the acceptance of corporate Quality Management (QM) policies and procedures, as appropriate
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of Quality Management activities throughout the health plan
- Review HEDIS® and member satisfaction survey data and action plans for improvement
- Review, monitor and evaluate program compliance against Dell Children's Health Plan, state, federal and accreditation standards
- Analyze and evaluate the results of Quality Improvement (QI) activities through review and approve the annual Quality Management program description, work plan and evaluation
- Determine and describe the program's overall effectiveness
- Consider the adequacy of resources, committee structure, practitioner participation and leadership involvement in the QM program and determine whether to restructure or change the QM program for the subsequent year based on its findings

- Provide oversight and ensure compliance of delegated services
- Assure interdepartmental collaboration, coordination and communication of Quality Improvement activities
- Measure compliance to medical and behavioral health practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability with cultural assessment
- Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety
- Make information available about the QM program to members and practitioners
- Assure the availability of QM program minutes to the appropriate state regulatory agency, as applicable
- Ensure practitioner participation in the QI program through planning, design, implementation or review, as well as through direct input from the practitioner members of the QM committee and PAC/ MAC, or other mechanisms that allow practitioner involvement
- Identify areas of opportunities and needed actions
- Follow up as appropriate

Provider Advisory Committee and Medical Advisory Committee (PAC/MAC)

The Provider Advisory Committee and Medical Advisory Committee (PAC/MAC) assesses levels and quality of care provided to members and recommends, evaluates and monitors standards of care. The PAC/MAC advises the health plan administration in any aspect of its policy or operation affecting network providers or members. The PAC/MAC approves and provides oversight of the Quality Management program and the health care management services program. Network providers are requested to be part of this committee structure to provide input on plan programs and performance improvement opportunities.

The PAC/MAC's responsibilities are to:

- Utilize ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities
- Review and provide input, based upon the characteristics of the local delivery system and approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization (clinical practice guidelines as well as Utilization Management criteria)
- Review clinical study design and results
- Develop and approve action plans/recommendations regarding clinical quality improvement studies
- Review and provide feedback regarding new technologies

- Oversee compliance of delegated services

Credentialing committee

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

- Conduct reviews for all providers who apply for participation in the network
- Review all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports
- Approve or deny providers submitted by a delegated credentialing entity
- Review and update credentialing policies and procedures
- Report physician corrective actions and sanctions imposed based upon recredentialing activity to the Quality Improvement Committee (QIC)
- Approve or deny providers for participation in the network and report decisions to the QIC
- Oversee sub-delegationed credentialing relationships
- Evaluates and reports the effectiveness of the credentialing program (e.g., timeliness, volume, percentage of clean files, percentage of complaints, etc.) to QIC.
- Reviews and evaluates all oversight monitoring activities and results on an annual basis (e.g., quarterly report results, annual audit results, and other oversight activities as applicable).

Peer review aspects of the credentialing committee

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- To participate in the implementation of the established peer review system
- To review and make recommendations regarding individual provider peer review cases
- To work in accordance with the executive medical director

Should investigation of a member complaint result in concern(s) regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the complaint. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the QIC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the QMC. The peer review process is a major component of the QIC monthly agenda. The peer review policy is available upon request.

Clinical practice guidelines

Using nationally recognized, scientific, evidence-based standards of care, we work with providers to develop clinical policies and guidelines for the care of members. The Medical Policy and Technology Assessment Committee oversees and directs us in formulating, adopting and monitoring guidelines.

Clinical practice guidelines are located on our secure website at **DellChildrensHealthPlan.com.** A copy of the guidelines can be printed from the website or you may call Provider Services at **1-844-781-2343 (TTY 7-1-1)** to receive a printed copy.

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

Focus studies, performance improvement projects (PIPs) and Utilization Management reporting requirements

Quality Management is involved in conducting clinical and service utilization studies along with HHSC required performance improvement projects (PIPs) that may or may not require medical record review or additional information from our participating providers. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

HEDIS® reporting data collection

Quality Management will be coordinating the annual HEDIS® project collecting administrative (claims) data and conducting chart medical record review to abstract data from providers charts that show demonstration of services received by members according to HEDIS® specifications. Provider participation is critical to successful data collection with each annual project.

Focus studies

Dell Children's Health Plan is required to conduct at least two focus studies per year based on state requirements. Dell Children's Health Plan utilizes national standards to create focus studies for clinical and non-clinical services, cost and utilization, and effectiveness of care. Each year Dell Children's Health Plan evaluates the effectiveness of its Quality Improvement program based on Utilization Review Accreditation Commission (URAC) standards for service and quality of care.

Utilization Management reporting requirements

The primary responsibility for monitoring appropriate use of health services is vested with Dell Children's Health Plan's medical director. The medical director will establish Utilization Management requirements that may be revised from time to time to assure the delivery of quality care in a cost-effective manner. The medical director will be assisted by the quality director who will act on behalf of the medical director in communicating with participating providers.

New technology

Our medical director and participating providers review and evaluate new medical advances in technology or the new application of existing technology in medical procedures, behavioral health procedures, pharmaceuticals and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment or new application of existing technology must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by Dell Children's Health Plan.

Chapter 9: **Utilization management**

Overview

We operate a comprehensive medical management program known as prior authorization and Utilization Management (UM). For questions about the UM processes, including UM criteria, call Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Medical review criteria

Dell Children's Health Plan utilizes nationally recognized, evidence-based medical policies and clinical UM guidelines. These policies are publicly available on the Dell Children's Health Plan medical policy and the clinical UM guideline subsidiary website at **DellChildrensHealthPlan.com.** These policies and guidelines can be obtained in hard copy by contacting Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Medical necessity determinations and the appropriateness of physical and behavioral health services follow a clinical criteria hierarchy that could include benefit coverage, medical necessity and prior authorization requirements. The list below provides the sequence of criteria application. If the criteria does not address the requested service either in total or at the required level of specificity, move to the next level in the hierarchy.

1. State Manuals/State Contracts/State Policy – Physical Medicine and Behavioral Health
2. Federal Mandates
3. Clinical UM Guidelines InterQual or MCG, as applicable
4. Hayes Technologies
5. National Comprehensive Cancer Network Clinical Guidelines
6. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs)
7. SHP/ACMIH Health Plan/Ascension Care Management Insurance Holdings Medical Coverage Policies and Ascension Therapeutic Affinity Group
8. Clinical peer reviewers may additionally utilize other criteria and evidence-based guidelines recognized by the American Board of Medical Specialties (ABMS); i.e The American College of Obstetrics and Gynecology (ACOG), The American Academy of Pediatrics (AAP), and The American Medical Association (AMA)

Federal law, state law and contract language, including definitions and specific contract provisions/ exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both

Dell Children's Health Plan medical policy and InterQual level-of-care criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

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

Criteria include:

- Texas Medicaid Provider Procedures Manual (TMPPM)
- InterQual
    - Acute care
    - Rehabilitation
    - Subacute care
    - Home care
    - Surgery and procedures
    - Imaging studies and x-rays
    - Specialty pharmacy non-oncology
    - Specialty pharmacy oncology
- Hayes Technologies

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

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

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

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

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

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

Utilization Management decision making affirmative statements

Dell Children's Health Plan, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

UM decision making is based only on appropriateness of care and service and existence of coverage.

Dell Children's Health Plan does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.

Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Hours of operation

Staff are available at least eight hours a day, Monday through Friday, during normal business hours for calls regarding UM issues.

Staff are available 24 hours a day, seven days a week to receive inbound communication by fax. Messages left on our telephone system will be returned within one business day.

TDD/TTY services and language assistance services are available for members as needed, free of charge.

Medically necessary services

Medically necessary means:

1. For Medicaid members birth through age 20, 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 may include consideration of other relevant factors, such as the criteria described in parts 2) (b-g) and 3) (b-g) below.

2. For Medicaid members over age 20 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
3. For Medicaid members over age 20 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

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

Prior authorization/notification process

For services that require prior authorization, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria. To determine if prior authorization or notification is required, see our Prior authorization Lookup Tool at **DellChildrensHealthPlan.com.**

Submit prior authorization requests using:

- Our provider portal **secure.healthx.com/Provider_2022 (preferred method)**
- Fax: **512-324-3014/1-844-981-3329**
- Call Utilization Management at: **1-855-962-4453 (TTY 7-1-1).**

Providers should submit a Prior Authorization Request Form, which is available on the provider website at **dellchildrenshealthplan.com/for-providers/prior-authorization** or by calling Provider Services at **1-844-781-2343 (TTY 7-1-1)**. Include the following information:

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

We are staffed with clinical professionals who coordinate services provided to members. These professionals are available during normal business hours and may receive inbound communication via fax or phone message 24 hours a day, 7 days a week to accept prior authorization requests. Upon receipt of a request for prior authorization, a Dell Children's Health Plan prior authorization assistant will verify eligibility and benefits prior to forwarding to the nurse or other qualified reviewer. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the reviewer will assist the requesting physician in identifying alternatives for health care delivery as supported by a Dell Children's Health Plan medical director.

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

If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of

payment. Claims for services are subject to all plan provisions, limitations and patient eligibility at the time services are rendered.

If the prior authorization documentation is incomplete or inadequate, the reviewer will not approve coverage of the request. In such instances, the reviewer will notify the provider to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the Dell Children's Health Plan medical director will make a determination based on the information previously received. Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial. For additional information, reference the peer-to-peer review process section of this manual.

The appropriate notice of action will be mailed to the member, the servicing provider, the requesting/ordering provider and the member's primary care physician. The notice of adverse determination will be mailed at least 15 business days prior to the date of the action. The notice includes an explanation of the member's appeal rights and state fair hearing/independent review organization rights and process.

Non-emergent outpatient and ancillary services—prior authorization and notification requirements

We require prior authorization for coverage of selected non-emergent outpatient and ancillary services. To determine if prior authorization or notification is required, see our prior authorization lookup tool at **dellchildrenshealthplan.com/for-providers/prior-authorization.**

The referring PCP or specialist physician is responsible for prior authorization. Requests for prior authorization with all supporting documentation must be submitted a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial. Additional information on administrative denials is in the administrative denial section below.

Non-emergent inpatient admissions

We require prior authorization of all inpatient non-emergent admissions, except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s). For a mother and her newborn(s), the guidelines are a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by cesarean section. We require prior authorization of maternity inpatient stays for any portion in excess of these time frames.

The referring primary care provider or specialist physician is responsible for prior authorization. Requests for prior authorization with all supporting documentation must be submitted a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

The hospital can confirm that an authorization is on file by accessing **secure.healthx.com/Provider_2022** or by calling our provider inquiry line at **1-844-781-2343 (TTY 7-1-1)**. If coverage of an admission has not been approved, the facility should contact us at **1-844-781-2343 (TTY 7-1-1)** so we can contact the physician directly to resolve the issue.

Administrative denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of

admissions, lack of prior authorization or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained or why clinical information was not submitted).

If Dell Children's Health Plan overturns its administrative decision, the case will be reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Emergent admission notification requirements

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

Inpatient admission reviews

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

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

Inpatient concurrent review

Each network hospital will have an assigned utilization management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record to determine the authorization of coverage for a continued stay. The review will be performed either at the hospital or by fax, telephone or through accessing electronic medical records.

The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours, at which time the reviews can be done less frequently than daily.

Initial clinical reviewers conduct continued reviews for the extension of an initial determination with a frequency that is based solely on the severity and complexity of the member's condition, or on necessary treatment and discharge planning activity. This will be in accordance with InterQual. Initial clinical reviewers shall not routinely conduct such reviews on a daily basis. This policy applies to both inpatient and outpatient settings.

When the clinical information received meets medical necessity criteria, approved days and bed level (if appropriate) coverage will be communicated to the hospital for the continued stay. If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will afford the attending physician

the opportunity to discuss the case prior to making a determination. For additional information, reference the peer-to-peer review process section of this manual.

If the medical director's decision is to deny the request, the appropriate notice of action will be mailed to the hospital, treating or attending practitioner, member's primary care provider and member. The notice of action includes an explanation of the member's appeal rights and external medical review/fair hearing/ independent review organization rights and process.

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

Peer-to-peer review process

If you receive a denial letter or notification that a case is under review and would like to discuss the case with our medical director, call **512-324-3013 (TTY 7-1-1)** or **1-855-962-4453 (TTY 7-1-1).** Be prepared to provide the
following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, date of birth and Dell Children's Health Plan ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and his or her phone number so we can reach out for additional information. Our medical director will make every effort to return calls within one business day.

Post-stabilization care services

Post-stabilization care services are covered services related to an emergency condition that are provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. We will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Discharge planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary. If the discharge is approved, our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician.

The attending physician is expected to coordinate with the member's primary care provider regarding follow-up care after discharge. The primary care provider is responsible for contacting the member to schedule all necessary follow-up care.

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

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

- Hospice facility
- Convalescent facility
- Home health care program (e.g., home IV antibiotics) or skilled nursing facility

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

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

Retrospective review

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

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

Confidentiality of information

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

conduct utilization management and other activities and processes listed above.

Urgent/after-hours care

We require members to contact their primary care provider in situations where urgent, unscheduled care is necessary. If the primary care provider is unable to see the member, you can refer him or her to one of our participating urgent care centers. If the member needs care during non-business hours, he or she can be seen by a provider who participates in our after-hours care program. Prior authorization by Dell Children's Health Plan is not required for a member to access a participating urgent care center or a provider participating in after-hours care.

Utilization timeliness standards

Utilization review timeliness standards:

- **Non-urgent pre-service:** For pre-certification of non-urgent care, a decision will be made within three business days.
- **Urgent pre-service:** For pre-certification of urgent pre-service care, a decision will be made within one business day but not later than 72 hours or three calendar days of receipt of the request for service.
- **Urgent concurrent:** For urgent concurrent care, a decision will be made within 24 hours of the receipt of request for service or notification of inpatient admission.
- **Post-service:** For post-service care, a decision will be made within 30 calendar days (considered in extenuating circumstances only. See retrospective review section).
- **Extensions:** Based upon insufficient information to make a decision, extensions to the standard time frames may be appropriate and can be used with certain restrictions. Appropriate notifications will be made if an extension is applicable.

Self-referrals

Service	Authorization for continued services
Obstetric/gynecological services	One well-woman checkup each year • Care related to pregnancy • Care for any female medical condition • Referral to specialist doctor within the network
Texas Health Steps	Members may self-refer to any Texas Health Steps certified provider.
Emergent care	No prior authorization or notification is required, regardless of network status with Dell Children's Health Plan.

Service	Authorization for continued services
Tuberculosis, sexually transmitted diseases, HIV/AIDS testing and counseling services	No prior authorization or notification is required for these services, regardless of network status with Dell Children's Health Plan.
Behavioral health—(non-participating providers must seek prior approval from Magellan)	Members may self-refer to any network behavioral health services provider by calling Member Services at **1-855-921-6284 (TTY 7-1-1)**. No prior approval from the primary care provider is required. Providers may refer members for services by: • Calling Provider Services at **1-844-781-2343 (TTY 7-1-1)** • Faxing referral information to our dedicated behavioral health faxes at **(866) 354-8758** for all services. • Our staff is available 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests.
Early Childhood Intervention (ECI)	Members may self-refer to local contracted ECI service providers. Dell Children's Health Plan providers must provide referral information to the legally authorized representative of any member birth to 3 years of age suspected of having a developmental disability or delay, or otherwise meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108, within seven calendar days from the day the provider identifies the member.
Family planning/sexually transmitted disease (STD)	No prior authorization or notification is required for these services.
Sterilization	No prior authorization or notification is required. Providers must submit claims with the Sterilization Consent Form. Claims submitted without the form will be denied.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum

bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

We strive to ensure that both Dell Children's Health Plan and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must implement procedures that demonstrate compliance with the HIPAA privacy regulations. This requirement is described in the following paragraphs.

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

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

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

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

Medical records standards require that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the HIPAA and other federal and state laws.

Misrouted protected health information

Providers and facilities are required to review all member information received from Dell Children's Health Plan to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, call Provider Services at **1-844-781-2343 (TTY 7-1-1)** for help.

Chapter 10: **Member management support**

Appointment scheduling

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

Service Coordination

Our Service Coordination program is part of a comprehensive health care management services program offering a continuum of services that include service coordination and disease management. The program helps to reduce barriers by identifying the unmet needs of members and assisting them in meeting those needs. This may involve coordinating care, assisting members to access community resources, providing disease-specific education or any number of interventions designed with a primary focus on allowing members to live as safely and as independently as possible. The programs are designed to make more efficient use of limited health care resources.

Service Coordination provides members with initial and ongoing assistance identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance their well-being, independence and integration in the community.

Key functions of Service Coordination:

1. Conduct detailed member assessments and identify care needs to include, but not limited to, physical health, mental health services and long-term support service needs
2. Develop a comprehensive service plan to address member needs—this includes coordination with treating providers and other participants of the member's care team. The team must include both physician and non-physician providers that the PCP determines are necessary for the comprehensive treatment of the Member. The team must:
    - Participate in Hospital discharge planning;
    - For behavioral health hospitalizations, participate in discharge planning
    - Participate in pre-admission Hospital planning for non-emergency hospitalizations;
    - Develop specialty care and support service recommendations to be incorporated into the Service Plan; and
    - Provide information to the Member, or when applicable, the Member's authorized representatives or LAR concerning the specialty care recommendations.

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

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

Objectives of the Service Coordination program:

- Maintain a comprehensive case management system to manage the needs of members with high service coordination needs in one or more domains (physical, behavioral or social)
- Utilize targeted high-intensity interventions that include the option of in-person interactions with a specific identified group of members defined by the state as "super-utilizers" due to excessive utilization patterns
- Identify barriers that may impede members from achieving optimal health
- Implement agreed-upon interventions to increase the likelihood of improved health outcomes, improving quality of life
- Reach out to effectively engage members and their families as partners in the service coordination process
- Reduce unnecessary, duplicated and/or fragmented utilization of health care resources
- Promote collaboration and coordination (at all levels of the health care delivery system) between physical health, behavioral health, the pharmacy program, and community-based social programs
- Foster improved coordination and communication among providers and with Dell Children's Health Plan staff
- Improve member and provider satisfaction and retention
- Comply with applicable contractual and regulatory requirements related to care coordination
- Identify opportunities to transition members to more appropriate federal/state programs (e.g., from STAR to STARKids or STAR+PLUS)
- Serve as advocates for members
- Assist members to match available benefits to their health care needs
- Promote effective strategies to prevent or delay relapse or recurrence through interventions, such as member education and improved member self-management
- Coordinate service coordination interventions with ongoing health promotion initiatives, such as dissemination of member education literature
- Help members and their families mobilize internal and external resources and strengths to improve their health outcomes and manage the costs of care
- Provide culturally-competent service coordination to members, families, and providers

- Maintain the highest quality of ethical standards, including maintenance of confidentiality, in all dealings with members
- Conduct quality management and improvement activities to ensure the highest possible level of service to members and their families
- Monitor outcomes of interventions to assist in evaluating and improving programs

Eligibility for Service Coordination

Any Dell Children's Health Plan member who is classified as high-risk or designated as having special health care needs and is interested in receiving service coordination will receive service coordination. The following members are considered high-risk or members with special health care needs:

- Members receiving Early Children Intervention services
- High-risk pregnant women
- Pregnant members with a previous pre-term birth
- Members with high-cost catastrophic cases or high service utilization
- Members with mental illness and co-occurring substance use disorder
- Members with a behavioral health diagnosis or condition that may affect a member's physical health or treatment compliance, including members with serious emotional disturbance or serious and persistent mental illness
- Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic or pharmacological intervention and evaluation (e.g., HIV/AIDS, respiratory illness, diabetes, heart disease, or kidney disease, or members receiving ongoing therapy or in-home/facility nursing or attendant care)
- Other members identified by the Service Coordination staff through the health risk assessment process, claims data mining, direct referrals from providers, members or family members.

Comprehensive member assessment

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

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

Using the structured assessment tool, service coordinators conduct telephone interviews or arrange for a home visit to collect and assess information from the members or their representatives. To complete the

assessment, service coordinators obtain information from the primary care providers and specialists, our continuous case-finding information and other sources to coordinate and determine current medical needs and non-medical services needed. This information is used to develop a comprehensive individualized service plan.

Hours of operation

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

Contact information

To contact a service coordinator, call Service Coordination at **512-324-3015 (TTY 7-1-1)** or **1-844-964-3015 (TTY 7-1-1)**. Providers may also contact the service coordination team via email at **dchp-cm@ascension.org**.

Members with Special Health Care Needs (MSHCN)

MSHCN means a member who both:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel (e.g., HIV/AIDS, respiratory illness, diabetes, heart disease, or kidney disease, or members receiving ongoing therapy or in-home/facility nursing or attendant care)
- Complex Care - has 2 or more chronic conditions

MSHCN also include the following:

- Early Childhood Intervention program participants
- Farmworker children
- Former foster care children
- Pregnant women who have a high-risk pregnancy, including members who have had a previous pre-term birth
- Members that have a mental illness with substance abuse
- Members with behavioral health issues that may affect physical health or treatment compliance
- Adoption Assistance and Permanency Care Assistance (AAPCA) program members
- Members with high-cost catastrophic cases or high service utilization, such as a high volume of ER or hospital visits.
- Other members identified by the Service Coordination staff through the health risk assessment process, claims data mining, direct referrals from providers, members or family members.

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

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

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

To refer a patient who may qualify as having special health care needs, contact Service Coordination at **512-324-3015 (TTY 7-1-1)** or **1-844-964-3015 (TTY 7-1-1)**. Providers may also contact the service coordination team via email at **dchp-cm@ascension.org**.

Communicable disease services

We cover communicable disease services to members. Communicable disease services help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs) and HIV/AIDS infection. Members can receive TB, STD and HIV/AIDS services outside of our provider network through the Texas Department of Health and Environmental Control clinics without any restrictions. Providers should encourage members to receive TB, STD and HIV/AIDS services through Dell Children's Health Plan to ensure continuity and coordination of a member's total care.

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

Control and prevention of communicable diseases

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

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

Health promotion

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

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

- Quarterly member, disease management and pregnancy newsletters
- Disease-specific health education booklets and targeted mailings
- Relationship development with community-based organizations to enhance opportunities for members

Women, Infants, and Children program (WIC)

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

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

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

- Are Medicaid-eligible
- Have a family income up to 185 percent of the federal poverty level

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

Case management for children and pregnant women

Need help finding and getting services?

You might be able to get a case manager to help you.

Who can get a case manager?

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

- Have health problems or
- Are at a high risk for getting health problems

What do case managers do?

A case manager will visit with you and then:

- Find out what services you need
- Find services near where you live
- Teach you how to find and get other services
- Make sure you are getting the services you need

What kind of help can you get?

Case managers can help you:

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

How can you get a case manager?

Call Dell Children's Health Plan at **1-855-921-6284** and ask to speak to a case manager for children and pregnant women.

Special Delivery pregnancy support program

We offer the Special Delivery pregnancy support program to all expectant mothers members. The program objective is to provide coordinated comprehensive prenatal management with the intent of identifying members prior to an adverse health event. We provide members with service coordination, education and incentives to promote healthy outcomes.

The Special Delivery program includes an obstetric (OB) service coordination program to improve birth outcomes of high-risk pregnant members. A team of experienced OB registered nurses supplements the care and information you provide to your patients. Members with the following conditions and issues will benefit most from service coordination:

- Multiple gestation
- History of preterm delivery with a past pregnancy
- Current preterm labor
- Noncompliant in keeping appointments
- Noncompliant in following their prescribed plan of care

Notification at **512-324-3015 (TTY 7-1-1)** or **1-855-962-4453 (TTY 7-1-1)** is required at the first prenatal visit. The Special Delivery program provides service coordination to:

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

Please help us identify members who may benefit from OB service coordination. You can make referrals to the Special Delivery program by calling **1-844-964-3015 (TTY 7-1-1)** and asking for an OB service coordinator.

Our members receive a pregnancy book about caring for yourself and your baby while pregnant that includes the importance of prenatal and ongoing doctor visits upon notification of their pregnancy. Upon completing certain checkups, some members are eligible for gift cards and items through Dell Children's Health Plan Member Rewards program, which is part of our value-added services.

Health education is provided and encouraged through prenatal and postpartum newsletters and trimester-specific booklets. Information about available health-related community services is provided to members as appropriate.

Chapter 11: **STAR and CHIP special access requirements**

General transportation and ambulance/wheelchair van

MTM Health provides Medicaid members and their attendants non-emergency medical transportation services by the most cost-effective modes to a reasonably close and medically appropriate provider. MTM Health can be reached at **1-844-867-2742**.

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

Over-the-phone interpreter services services

Dell Children's Health Plan provides language interpretation services to translate multiple languages at no cost to providers or members. We do this through the Language Line, which may be accessed by calling Provider Customer Service at 1-844-781-2343. Provider Customer Service will then contact the Language Line as a third-party.

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

Face-to-face interpreter services

Dell Children's Health Plan will arrange, with at least a 72-hour prior notice, to have someone who speaks the member's language meet the patient at the provider's office for their appointment. We will set up and pay for a sign language interpreter to assist members who are deaf or hard of hearing. The service can be arranged by calling Provider Customer Service at 1-844-781-2343 (TTY 7-1-1). Interpreter services should be requested at least 72 hours before the appointment.

MCO/provider coordination

Dell Children's Health Plan clinical and operational staff is available to assist you in coordinating care and supporting your care plans for your patients. This includes members who are new to our plan and require transition assistance, have complex or special needs, or need any type of social and/or clinical help. Our provider hotline can assist with PCP assignment or change (including designation of a specialist as PCP), specialist information and ancillary resource availability. Our utilization management and case/disease management staff can assist you with out-of-network providers, authorization issues, expedited care requirements and member-facing support. The latter includes member outreach, education, care coordination and ongoing guidance.

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

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

Contact us at **1-844-781-2343 (TTY 7-1-1)** for assistance with utilization management and service coordination/disease management for your Dell Children's Health Plan patients.

Reading/grade level consideration and cultural sensitivity

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

Providers should be culturally sensitive to members or parents/guardians. Some actions or words a provider uses may be interpreted by the member or parent/guardian in the wrong way. If you need additional information about cultural sensitivity, contact Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Each office is required to ensure compliance with applicable state and federal regulations for handicapped access. The provider must have a mechanism in place to allow members with special health care needs to have direct access to a specialist as appropriate for the member's condition and identified needs, such as a standing referral to a specialty physician or Behavioral Health Provider.

Chapter 12: **Disease management programs**

Overview

Our Disease Management program is based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic conditions. Our team is made up of registered nurses, masters level social workers, and community health workers. We provide support to members through a holistic process to address members' physical and behavioral health needs in addition to addressing their non-medical drivers of health behaviors through multiple programs. Our Disease Management programs include:

- Asthma
- Complex Care - 2 or more chronic conditions
- Diabetes
- Hypertension
- Major depressive disorder
- Anxiety
- Oncology
- And more

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

Who is eligible?

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

Referring patients to Disease Management programs

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

Program features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Ongoing process and outcomes measurement, evaluation and management

- Ongoing communication with providers regarding patient status
- Continuous patient self-management education including:
    - Primary prevention
    - Behavior modification programs and compliance/surveillance
    - Home visits and service coordination for high-risk members

Our Disease Management programs are based on nationally approved clinical practice guidelines, located at **dellchildrenshealthplan.com/for-providers/care-management-support.** A copy of the guidelines can be printed from the website or call Provider Services at **1-844-781-2343 (TTY 7-1-1)** to receive a copy.

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

Hours of operation

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

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

Contact information

Refer members for service coordination in one of two ways:

- Call Service Coordination at **512-324-3015 (TTY 7-1-1)** or **1-844-964-3015 (TTY 7-1-1)**;
- Fax a completed Service Coordination/Disease Management Referral Form to **512-324-3016**

Disease Management provider rights and responsibilities

You have the right to:

- Have information about Dell Children's Health Plan, including:
    - Provided programs and services
    - Our staff
    - Our staff's qualifications
    - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients

- Be informed of how we coordinate our interventions with your patients' treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about our Disease Management program as outlined in the Dell Children's Health Plan provider complaint procedure

Chapter 13: **Provider responsibilities**

Provider rights and responsibilities

Providers' bill of rights

Each health care provider who contracts with HHSC or subcontracts with Dell Children's Health Plan to furnish services to members will be assured of the following rights:

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

Network provider general responsibilities

Each health care provider contracted with Dell Children's Health Plan has the following general responsibilities:

- The Primary Care Provider (Medical Home) is responsible for serving Dell Children Health Plan's STAR, CHIP, and CHIP Perinate members.
- While enrolled with Dell Children's Health Plan, members have the right to designate an OB/GYN as their Primary Care Provider.

- While enrolled with Dell Children's Health Plan, members with disabilities, special health care needs, and or Chronic or Complex conditions, have the right to designate a specialist as their Primary Care Provider as long as the specialist agrees.
- The provider must adhere to Dell Children's Availability and accessibility rules explained in this document.
- The Primary Care Provider may provide behavioral health-related services within the scope of its practice.
- The primary care provider or main dentist ensures members have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.
- Network providers must inform both Dell Children's Health Plan and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.
- Network providers must inform Dell Children's Health Plan immediately if they wish to initiate plan termination from our network.
- While enrolled with Dell Children's Health Plan, the member has the right to select and have access to, without a Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery.
- Providers ensure members understand the right to obtain medication from any network pharmacy.
- Member information on advance directive.
- Although a referral is not required, any referrals that are given to specialists or other health-related services must be documented. The coordination of referrals and services will be provided between Primary Care Provider and the specialist.
- Ensure that the arrangement of referrals for care and service are within the Dell Children's Health Plan network.
- The provider must submit justification, in the form of a prior authorization, to Dell Children's Health Plan regarding Out-of-Network referrals, including partners not contracted with the health plan.
- Verify member eligibility and obtain prior authorization for services as required by Dell Children's Health Plan.
- Primary Care Provider may provide behavioral health-related services within the scope of its practice.
- Facilitate help to a member to find dental care. The dental plan member ID card lists the name and phone number of a member's main dental home provider. The member can contact the dental plan to select a different main dental Home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within 5 business days. If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at 1-800-964-2777.
- Facilitate and ensure that members have access to a second opinion.
- Specialty Care Providers must adhere to availability and accessibility standards.

- Dell Children's Health Plan must ensure continuity of care such that the care of newly enrolled members is not disrupted or interrupted in situations of gathering pregnant woman information, member moves out of the service area, or gathering information about preexisting conditions not imposed.
- Providers must ensure that medical records meet standards and reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.
- Providers are required to inform members on how to report Abuse, Neglect, and Exploitation. Please see Appendix B in this document.
- Providers must ensure they have trained staff on how to recognize and report Abuse, Neglect, and Exploitation. Please see Appendix B in this document.
- The Provider must provide Dell 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).
- The provider must follow Community First Choice guidelines. Please see Appendix A in this document.
- Provide Dell Children's Health Plan members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Dell Children's Health Plan clinical and nonclinical guidelines and within the practice of your professional license.
- Treat all Dell Children's Health Plan members in a fair and nondiscriminatory manner and with respect and consideration.
- Abide by the terms of your Seton Health Plan Network Services Agreement.
- Comply with all of Dell Children's Health Plan policies and procedures, including those found in this provider manual and any future updates or supplements.
- Facilitate in-patient and ambulatory care services at in-network facilities.
- Maintain a facility that promotes patient safety.
- Participate in the Dell Children's Health Plan Quality Improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify Dell Children's Health Plan if you are undergoing any type of legal or regulatory investigation or if you have agreed to a written order issued by the state licensing agency for your profession.
- Notify Dell Children's Health Plan if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in an amount that meets Dell Children's Health Plan credentialing requirements and/or state-mandated requirements.

Advance directives

We adhere to the Patient Self-Determination Act and maintain written policies and procedures regarding

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

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

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

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

Americans with Disabilities Act requirements

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

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

Reporting legal or administrative proceedings, changes in address and practice status

Within 30 days of occurrence, a provider shall give written notice to us if he or she is named as a party in any civil, criminal or administrative proceeding. Failure to provide such timely notice to us constitutes grounds for termination of the provider's contract with us.

Providers are required to notify us of a change in address or practice status 30 days prior to the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of

termination must adhere to the advance notice timelines stated in the provider's agreement. Please submit changes to:

shproviderservices@seton.org
or
Attn: Provider Relations
Dell Children's Health Plan
1345 Philomena St., Ste. 305
Austin, TX 78723

Nondiscrimination for Vaccine Status

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

Appointments

Routine care

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

Urgent care

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

Emergency care

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

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman)

Appointment and access standards

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

Standard name	Dell Children's Health Plan
Emergency services	Immediately upon member presentation at the service delivery site including at non-network and out-of-area facilities
Urgent care	Within 24 hours
Routine primary care	Within 14 days
Routine specialty care	Within 21 days
Preventive health: adult (21 years and older)	Within 90 days
Preventive health: child (new member)	For new members birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps, should be offered as soon as practicable and within 90 days of enrollment
Preventive health: child less than 6 months old	Within 14 days
Preventive health: child age 6 months through 20 years	Within 60 days
Prenatal care: initial visit	Within 14 days
Prenatal care high-risk or third trimester: initial visit	Within five days or immediately if an emergency exists
Prenatal care—after initial visit	Based on the provider's treatment plan
Behavioral health: non-life threatening emergency	Within 6 hours

Standard name	Dell Children's Health Plan
Specialty Therapy evaluations	Within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral
Behavioral health: urgent care	Within 24 hours
Behavioral health: routine care—initial visit	14 calendar days
Behavioral health: follow-up routine care	Within two weeks for behavioral health conditions (three weeks for medical)
After-hours care	For primary care providers: Practitioners accessible 24/7 directly or through answering service. • Answering service or recording assistance is in English and Spanish. • Member reaches on-call physician or medical staff within 30 minutes.
Case Management for Children and Pregnant Women services	Within 14 Days

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

Member missed appointments

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

Dell Children's Health Plan members who frequently cancel or fail to show up for appointments without

rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at **1-844-781-2343 (TTY 7-1-1)** or health plan member advocate to address the situation. Our staff will contact the member and provide more extensive education and/or service coordination as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and adhering to the primary care provider's recommended plan of care. Providers may not bill us or our members for missed appointments.

Continuity of care

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

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

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

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

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

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

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

For new members who have been diagnosed with a terminal illness, we will approve out-of-network care by existing providers for up to nine months while enrolled with Dell Children's Health Plan.

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

Member moves out of service area

We provide or pay out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which he or she is enrolled in Dell Children's Health Plan.

Pre-existing condition not imposed

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

Covering physicians

During a provider's absence or unavailability, he or she needs to arrange for coverage for his or her members. The provider will either:

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

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

Credentialing and recredentialing

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

Providers must submit all requested information necessary to complete the credentialing or recredentialing process. Dell Children's Health Plan uses Verisys (formerly known as Aperture) to conduct the primary source verification on our behalf. You can expect Verisys to reach out by email, mail, and phone. Any requests for missing information must be submitted directly to Verisys. In addition, all providers will need to complete an online application through our credentialing database, MD-Staff. MD-Staff will send you a unique link via email with directions on how to complete your application.

Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures. Credentialing is approved for a three-year period and providers will be notified of initial credentialing decisions within thirty (30) business days of the credentialing committee decision.

As an applicant for participation in our network, each provider has the right to review information

obtained from other sources during the credentialing process, the right to correct erroneous information, and the right to obtain information about the status of their initial or recredentialing application via email at **txcredentialing@ascension.org**. Upon notification from us of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

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

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

Dell Children's Health Plan will provide expedited credentialing for certain provider types and allow services to members on a provisional basis as required by Texas Government Code §533.0064 and our state contract with HHSC. Provider types included are licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and psychologists. The provider must meet the following criteria:

- Be a member of a provider group already contracted with Dell Children's Health Plan
- Be Medicaid-enrolled
- Agree to comply with the terms of the existing provider group contract
- Submit all documentation and other information required by us to begin the credentialing process

At least once every three years, we will review and approve the credentials of all participating licensed and unlicensed providers who participate in the Dell Children's Health Plan network. Recredentialing efforts begin eight months prior to the end of the current credentialing period. The process will take into consideration provider performance data including member complaints and appeals, quality of care and utilization management. Providers who do not respond or submit complete recredentialing information prior to their recredentialing date will be terminated. Upon termination, providers must begin the contracting and credentialing process from the beginning to rejoin the network. SHP may extend a practitioner's recredentialing cycle time frame beyond 36 months if the practitioner is on active military assignment, on medical leave (e.g., parental leave), or on sabbatical. This will be documented in the practitioner file and the practitioner will be recredentialed within 60 days of the return to practice. Providers will not be notified of their recredentialing status unless there is a change in their credentialing status such as termination, suspension, or if recredentialed for a shorter time period than 3 years. Written notices of an adverse decision will be sent within fifteen (15) business days of the credentialing committee decision.

If you have questions about the credentialing process, check status, or update your credentials, you can reach out to our credentialing team via email at **txcredentialing@ascension.org**.

Providers are required to notify us of a change in address or practice status 30 days prior to the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement.
Submit changes to:

SHPProviderservices@seton.org (preferred method)
or in writing to:
Provider Relations
Dell Children's Health Plan
1345 Philomena St., Ste. 305
Austin, TX 78723

Credentialing decision appeal process

If an adverse initial credentialing or recredentialing decision is made, Dell Children's Health Plan will notify the provider of unsuccessful credentialing within fifteen (15) business days. The notification shall include the reason for the adverse decision, a request for additional information (if applicable) and the right of the provider to request a hearing within thirty (30) business days. If the adverse decision is upheld, SHP is responsible for ensuring that adverse actions are reported to appropriate agencies.

Practitioner office site quality

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

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

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space, or adequacy of medical/treatment records
- Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members' health and well-being
- When a pattern related to the quality of the site is identified
- To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations. The site review includes but is not limited to an assessment of the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Appointment availability
- Adequacy of medical record keeping to include current, detailed and organized documentation and confidentiality practices (medical record score marked separately)

- Medical records shall be available for review upon reasonable advance notice (five business days)
- Medical records stored in a secure manner away from public access
- Adequate policies covering the duties of physician assistants, advanced practice nurses, dental hygienists and/or other individuals hired to assess the health needs of members (duties, licensure, delegation, collaboration and supervision)

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

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

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

Cultural competency

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

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

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider. It also impacts the member's adherence to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers

- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system

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

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

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

Cultural awareness needed:

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

Knowledge needed:

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

Skills needed:

- The ability to understand the basic similarities and differences between and among the cultures of the persons served

- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and an understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to utilize culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to recognize challenges related to literacy and provide appropriate and understandable information
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The ability to accept ethnic differences among people and understand how these differences affect the treatment process
- A willingness to work with clients of various ethnic minority groups

Early Childhood Intervention (ECI) services

We contract with qualified ECI providers to provide ECI covered services to members from birth to 3 years of age who have been determined eligible for ECI services. Members are permitted to self-refer to local ECI service providers without a referral from the member's primary care provider. Our providers are required to identify and provide referral information to the legally authorized representative (LAR) of any member birth to 3 years of age suspected of having a developmental disability or delay or otherwise

meeting eligibility criteria for ECI services in accordance with 40 TAC Chapter 108 within seven calendar days from the day the provider identifies the member. HHSC provides information and publications on its website at **hhs.texas.gov/services/disability/early-childhood-intervention-services-eci,** which should be used as a resource by providers to identify children in need of ECI services. The local ECI program will determine eligibility for ECI services using the criteria contained in 40 TAC Chapter 108.

The member's LAR must be informed that ECI participation is voluntary. Dell Children's Health Plan must provide medically necessary services to a member if the member's LAR chooses not to participate in ECI.

The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The individual family service plan (IFSP) is an agreement developed by an interdisciplinary team that includes the member's LAR, the ECI service coordinator, ECI professionals directly involved in the eligibility determination and member assessment, ECI professionals who will be providing direct services to the child, and other family members, advocates or other persons as requested by the LAR. If the member's LAR provides written consent, the member's primary care provider or Dell Children's Health Plan staff may be included in IFSP meetings.

The IFSP is a contract between the ECI contractor and the member's LAR. The LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the member as well as information related to family needs and concerns. If the member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the member with Dell Children's Health Plan and the primary care provider to enhance coordination of the plan of care. These sections of the IFSP may be included in the member's medical record or service plan.

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

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

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

Eligibility verification

If a member calls Dell Children's Health Plan to change his or her primary care provider, the change will be effective the same business day. The primary care provider should verify that each Dell Children's Health Plan member receiving treatment in his or her office is on the membership listing. For questions regarding a member's eligibility, providers may visit **secure.healthx.com/Provider_2022** or call the provider inquiry line at **1-844-781-2343 (TTY 7-1-1)**.

Emergency services

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

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

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

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

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

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

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

- Police, fire and EMS departments

- Juvenile probation
- The judicial system
- Child protective services
- Chemical dependency agencies
- Emergency services
- Local mental health authorities

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

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on Dell Children's Health Plan. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the Dell Children's Health Plan concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Fraud, waste and abuse

General obligation to prevent, detect and deter fraud, waste and abuse

As recipients of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect and deter fraud, waste and abuse. Our commitment to detecting, mitigating and preventing fraud, waste and abuse is outlined in our corporate compliance program. As part of the requirements of the federal Deficit Reduction Act, each Dell Children's Health Plan provider is required to adopt our policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state-funded health care programs in which we participate. Electronic copies of this policy and our Code of Business Conduct and Ethics are available at **DellChildrensHealthPlan.com**.

To meet the Deficit Reduction Act requirements, providers must adopt our fraud, waste and abuse policies. Additionally, providers must distribute the policies to any staff members or contractors who work with us. If you have questions or would like to have more details concerning our fraud, waste and abuse detection, prevention and mitigation program, please contact our chief compliance officer.

If a network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the network provider must:

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

Importance of detecting, deterring and preventing fraud, waste and abuse

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

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

Provider fraud, waste and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

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

Member fraud, waste and abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking

- Impersonation fraud
- Misinformation and/or misrepresentation
- Subrogation and/or third-party liability fraud
- Transportation fraud

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

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

Reporting waste, abuse or fraud by a provider or member

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

Let us know if you think a doctor, dentist, pharmacist at the drug store, other health care providers or a person getting benefits is doing something wrong. Doing something wrong could be 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 someone has in order

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

- Call the Office of Inspector General (OIG) Hotline at **1-800-436-6184**.
- Visit **oig.hhs.gov/fraud/report-fraud** and click the red Report Fraud box to complete the online form.
- Report directly to your health plan:

  Attn: Compliance Officer
  Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723

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

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

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

When reporting about someone who receives benefits, include:

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

ImmTrac2

ImmTrac2 is the DSHS statewide immunization and tracking database system that:

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

Providers are required to:

- Submit all immunization information of members who are 17 years of age and younger to ImmTrac2 within 30 days of administration of the vaccine.
- Obtain written consent to release a child's individual immunization data to ImmTrac2.
- Verify that the Texas birth certificate registration form includes a parental consent statement.

Providers should register with ImmTrac at **dshs.texas.gov/immunize/immtrac.**

Laboratory services (outpatient)

All outpatient laboratory tests should be performed at a Dell Children's Health Plan in-network reference lab or a network facility outpatient lab. The exception to this requirement is when the service being performed is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test or for Texas Health Steps. Visit the CMS website at **CMS.hhs.gov** for a complete list of CLIA-approved tests.

CLIA requires all laboratories serving Medicaid clients to maintain a certificate of registration or a certificate of waiver.

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

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

Locum tenens

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

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

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

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

Member record standards

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

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

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

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

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

8. Immunizations. For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.

9. Diagnostic information. Documentation of clinical findings and evaluation for each visit should be noted.

10. Medication information. This notation includes medication information/instruction(s) to the patient.

11. Identification of current problems. Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.

12. Instructions. The record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health conditions.

13. Smoking/alcohol/substance abuse. A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.

14. Preventive services/risk screening. The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.

15. Consultations, referrals and specialist reports. Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.

16. Emergencies. All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the primary care provider's panel must be noted.

17. Hospital discharge summaries. Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.

18. Advance directive. Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision-making for individuals who are incapacitated.

19. Security. Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.

20. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.

21. Documentation. Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.

22. Multidisciplinary teams. Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.

23. Integration of clinical care. Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:

    - Notation of screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
    - Notation of screening and referral by behavioral health providers to primary care providers when appropriate
    - Notation of receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals
    - A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the primary care provider
    - A written release of information that will permit specific information-sharing between providers
    - Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

Patient visit data

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

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
2. Behavioral health treatment that includes at-risk factors (danger to self/others, ability to care for self, affect/perceptual disorders, cognitive functioning and significant social health) for behavioral health patients
3. An admission or initial assessment that must include current support systems or lack of support systems
4. An assessment for behavioral health patients (performed at each visit) of client status/symptoms regarding the treatment process; assessment may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period
5. A plan of treatment that includes activities/therapies and goals to be carried out
6. Diagnostic tests

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

We will systematically review medical records to ensure compliance with these standards. Compliance with medical record performance standards is a medical record score of 80 percent, including six clinical elements that must be met. Clinical medical record audit and office site visit forms are available on our website at **DellChildrensHealthPlan.com.** We will institute actions for improvement when standards are not met.

We maintain an appropriate record keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of 45 CFR 74.164, i.e., records must be retained for seven years from the date of service.

Member's right to designate an OB/GYN

Dell Children's Health Plan allows the member to pick an OB/GYN, but this doctor must be in the same network as the member's primary care provider.

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

Non-compliant Dell Children's Health Plan members

Call Provider Services at **1-844-781-2343 (TTY 7-1-1)** if you need help working with a member regarding:

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

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

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

- Not make a removal decision based on the member's health status or utilization of services which are medically necessary for treatment of the member's condition
- Send a certified letter to the member or head of household stating that the member must select a new primary care provider within 30 days of the notice.
- Send a copy of the letter to:
  Member Advocate
  Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- Continue to provide care to the member until the effective date of the assignment to a new primary care provider
- Not take any retaliatory action against a non-compliant member

In extreme situations where a member consistently refuses to cooperate with us and our providers, misuses or loans their member ID card to another person to obtain services, or refuses to comply with managed care restrictions, we may request that HHSC disenroll the member from Dell Children's Health Plan. If the member disagrees with the disenrollment, they may access our member complaint process and the HHSC fair hearing process.

Primary care providers

Medical home

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

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

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

The providers in the medical home are knowledgeable about the member's and family's special health related social and educational needs. The medical home providers are connected to community resources that will assist the family in meeting those needs. When a primary care provider refers a member for a

consultation, specialty/hospital services or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through the primary care provider.

Primary care provider types (network limitations)

Physicians with the following specialties can apply for enrollment with us as primary care providers:

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

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

Primary care provider responsibilities

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

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers (both in and out-of-network); provide coordination necessary for referrals to specialists (both in and out-of-network); and maintain a medical record of all services rendered including those rendered by other providers
- Make referrals for specialty care for members on a timely basis, based on the urgency of the member's medical condition, but within no later than 30 calendar days from the date the need is identified or requested
- Provide 24-hour-a-day, 7-day-a-week coverage in accordance with the after-hours coverage section of this manual; regular hours of operation should be clearly defined and communicated to members
- Be available to provide medically necessary services

- Ensure that covering physicians follow the referral/prior authorization guidelines
- Provide services ethically and legally in a culturally competent manner; meet the unique needs of members with special health care needs
- Participate in any system established by Dell Children's Health Plan to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
- Make provisions to communicate in the language or fashion primarily used by his or her patients
- Participate and cooperate with Dell Children's Health Plan in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Dell Children's Health Plan
- Participate in and cooperate with the Dell Children's Health Plan complaint procedures; we will notify the provider of any member complaint
- Not balance-bill members; however, the primary care provider is entitled to collect applicable copays for certain CHIP services; Medicaid members do not have an out-of-pocket expense for covered services
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan, in compliance with Occupational Safety and Health Administration standards, regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Support, cooperate and comply with the Dell Children's Health Plan quality improvement program initiatives and any related policies and procedures
- Provide quality care in a cost-effective and reasonable manner
- Inform Dell Children's Health Plan if a member objects to provision of any counseling, treatments or referral services for religious reasons
- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the member the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis; give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments which may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings

- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies and poison control centers to provide high-quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research related care
- Inform both Dell Children's Health Plan and the HHSC administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101 within one business day

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

After-hours coverage

We encourage primary care providers to offer extended office hours to include nights and weekends.

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

- Have the office telephone answered after hours by an answering service that can contact the primary care provider or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.
- Have the office telephone answered after normal business hours by a recording in both English and Spanish; the recorded message should direct the member to call another number to reach the primary care provider or another provider designated by the primary care provider; someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone; the person answering the calls must be able to contact the primary care provider or a designated Dell Children's Health Plan network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are NOT acceptable:

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

- Returning after-hours calls outside of 30 minutes

New members

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

Primary care provider changes and transfers

We encourage members to remain with their primary care providers to maintain continuity of care. However, members may request to change a primary care provider for any reason by contacting Member Services at **1-855-921-6284 (TTY 7-1-1)**. The member's name will be provided to the primary care provider on the membership roster.

Members can call to request a primary care provider change any day of the month. Primary care provider change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Specialist as a primary care provider

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

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

The specialist must:

- Agree to serve as the member's primary care provider
- Meet the requirements for primary care provider participation (including contractual obligations and credentialing)
- Provide 24/7 access to care
- Coordinate the member's health care, including preventive care
- The provider has admitting privileges, or makes referral arrangements with a Provider who has admitting privileges, to a local Hospital that includes admissions to pediatric units

When such a need is identified, the member or specialist must contact the Dell Children's Health Plan Service Coordination department and complete a Specialist as PCP Request form. A service coordinator

will review the request and submit it to our medical director. We will notify the member and the provider of our determination in writing within 30 days of receiving the request.

The designation cannot be retroactive. If the request is approved, we will not reduce the compensation that is owed to the original primary care provider before the date of the new designation of the specialist as primary care provider. If we deny the request, however, the member may appeal the decision through our member complaint process. Under that process, we must respond to the member's complaint in writing within 30 days. For more information, call Provider Services at **1-844-781-2343 (TTY 7-1-1)**.

Provider disenrollment process

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

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

Provider marketing

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

Providers must comply with HHSC's marketing policies and procedures as set forth in Chapter 4.3 of the HHSC Uniform Managed Care Manual, available at **hhsc.state.tx.us/Medicaid/Managed-Care/UMCM.**

Provider quality incentive programs

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

Radiology

When both a physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading

the film. If the physician feels there is a problem with the reading diagnosis, he or she should contact the radiological facility to discuss the concern.

Second opinions

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

The second opinion must be obtained from a network provider (see the provider directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Dell Children's Health Plan will use single case agreements with Out-of-Network providers to facilitate a Member's access to a second opinion. Once approved, the primary care provider will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The primary care provider will notify the member of the outcome of the second opinion.

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

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

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

Referrals

Providers can refer patients to participating providers and facilities when available. If you need to refer a member to an out-of-network provider, you must notify Dell Children's Health Plan by requesting a prior authorization. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network. For more information on how to submit a prior authorization, please see our section on Utilization Management.

Specialty care providers

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

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

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

Specialty care provider roles and responsibilities

Responsibilities of specialists contracted with Dell Children's Health Plan include:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information, including source of referral and referral number to Dell Children's Health Plan
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and prior authorization of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's primary care provider on a timely basis following a referral or routinely scheduled consultative visit
- Notifying the member's primary care provider when scheduling a hospital admission or any procedure requiring the primary care provider's approval
- Coordinating care (as appropriate) with other providers involved in rendering care for members, especially in cases involving medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist shall:

- Manage the medical and health care needs of members to encompass:
    - Monitoring and following up on care provided by other providers
    - Coordinating referrals to other specialists and other providers (both in- and out-of-network)
    - Maintaining a medical record of all services rendered by the specialist and other providers
- Provide coverage 24 hours a day, 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically and legally and in a culturally competent manner that meets the unique needs of members with special health care requirements
- Participate in Dell Children's Health Plan systems that facilitate record sharing, subject to applicable confidentiality and HIPAA requirements
- Participate in and cooperate with Dell Children's Health Plan in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Dell Children's Health Plan
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to members
- Participate in and cooperate with the Dell Children's Health Plan complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist

- Not balance bill members
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members; this is to occur in accordance with applicable state laws and regulations
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
- Support, cooperate and comply with Dell Children's Health Plan Quality Improvement program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform Dell Children's Health Plan if a member objects for religious reasons to the provision of any counseling, treatment or referral services
- Treat all members with respect, dignity and appropriate privacy; treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations
- Provide members complete information concerning diagnosis, evaluation, treatment and prognosis; give members the opportunity to participate in decisions involving health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments that may be self-administered
- Contact members (when clinically indicated) as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings
- Establish and maintain a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies and poison control centers to provide quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to non-research related care
- Within 30 days of occurrence, provide written notice to Dell Children's Health Plan if the specialist is named as a party in any civil, criminal or administrative proceeding; failure to provide timely notice to Dell Children's Health Plan constitutes grounds for termination of the specialist's contract with Dell Children's Health Plan

- Report any suspicion or allegation of member abuse, neglect or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002 and Texas Family Code §261.101 within one business day

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

Texas Vaccines for Children program

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

How to help a member find dental care

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

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

Cancellation of product orders

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

For automated refill orders for covered products, Dell Children's Health Plan requires the Provider to confirm with the Member that a refill, or new prescription received directly from the physician, should be delivered. Further, Dell Children's Health Plan will ensure that the

Provider completes a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code § 291.34. The Member or Member's LAR must have the option to withdraw from an automated refill delivery program at any time.

Reading/grade level consideration

Millions of Americans are functionally illiterate and many millions more are only marginally literate. Many of our members may have limited ability to understand and read instructions but most people with literacy problems are ashamed and will try to hide their problem from providers. Low literacy may mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Materials provided to members should be written at a fourth- to sixth-grade reading level. Be sensitive to the fact that the member may not be able to read instructions for taking medicine or for treatment and to the embarrassment the member may feel about limited literacy. If interpreter services are needed, call Provider Services at **1-844-781-2343 (TTY 7-1-1).**

Chapter 14: **Electronic Visit Verification**

General information about EVV

What is EVV?

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

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

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 a State-Provided 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 also requires the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

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

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

Who must use EVV?

The following must use EVV:

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

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

EVV Systems

Do Providers and FMSAs have a choice of EVV Systems?

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

- **EVV vendor system.** An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.
- **EVV proprietary system.** An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of the state-provided EVV system vendor. 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 HHSC EVV Business Rules for Proprietary Systems.
  - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

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 a state provided EVV system, a Provider or FMSA, must complete, sign, date and submit the EVV Provider Onboarding Form directly to the state provided EVV system vendor.
- 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.

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 state-provided **EVV vendor.** Providers or FMSA's signature authority must sign and submit an electronic EVV Proprietary System Request Form and complete the **EVV PSO Onboarding Process** to receive written approval to use an EVV proprietary system.

- 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 a state-provided EVV system vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer to Question #18; 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.
        - For FMSAs only, create unique CDS Employer profiles and credentials depending on the option selected on Form 1722, Employer's Selection for Electronic Visit Verification Responsibilities.

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

- If a Provider or FMSA selects a 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 a state provided EVV system to an EVV proprietary system;
- Transfer from an EVV proprietary system to a state provided EVV system; 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:

- Proprietary system operators (PSOs) who want to transfer to the state provided EVV system must request a transfer with TMHP at least 120 days before the desired system transfer effective date. The transfer may occur before the 120 days if a PSO and the state provided EVV system vendor agree on an earlier date.
    - The 120-day transfer time frame allows for:
        - Training on the state provided EVV system
        - Transfer of data if requested by the PSO.
        - Completion of all tasks necessary to use the state provided EVV system.

FMSAs approved as a PSO must tell CDS employers at least 60 days in advance of the planned system transfer effective date to allow time to retrain CDS employers and their CDS employees on the state provided EVV system.

- The PSO must:
    - Complete a Termination Form with their current EVV proprietary system 120 days before the desired system transfer effective date.
    - Complete an EVV Provider Onboarding Form with the state provided EVV system vendor 120 days before the desired Go-Live date.
        - Select transfer on the form.
        - Submit to the state provided EVV system vendor.

Transfer process:

- The state provided EVV system vendor will contact the signature authority or the EVV System Administrator within five business days of receipt to confirm the request to transfer and acknowledge receipt.
- The PSO will contact the EVV proprietary system vendor to discuss the transfer request and agree on a date to transfer data to the state provided EVV system.
- The EVV proprietary system vendor will communicate the date to transfer data to the state provided EVV system vendor and TMHP.
- The state provided EVV system vendor must import data within five business days of receipt on behalf of the PSO.
- The state provided EVV system vendor will tell the PSO and TMHP within five business days of completing the data transfer.
- The state provided EVV system vendor will provide further onboarding and EVV system training instructions.

PSOs transferring to the state provided EVV system:

- Must follow EVV Policy Handbook, section 4100, EVV System Selection and section 4700, EVV System Transfer.
- Must make sure all staff, service providers and CDS employers complete EVV system training before using the state provided EVV system.
    - CDS employers must make sure their employees complete training before using the state provided EVV system.
    - Will not receive a grace period for complying with EVV Policy.
    - May have EVV claims denied or recouped.
- How to transfer to an EVV Proprietary System
    - Providers (including program providers approved as proprietary system operators (PSOs)),

or FMSAs (including FMSAs approved as proprietary system operators (PSOs)) who want to transfer to an EVV proprietary system from the state provided EVV system or another EVV proprietary system, must:

- Submit an electronic EVV Proprietary System Request Form through the EVV Portal.
- Submit a Termination Form to the state provided EVV system vendor or current EVV proprietary system vendor within seven days of TMHP accepting the program provider or FMSA into an Operational Readiness Review (ORR) session.
- Accept assignment to an ORR and complete all steps in EVV Policy Handbook, section 5000, EVV Proprietary System.

Transferring from the state provided EVV system to an EVV proprietary system or from one EVV proprietary system to another can only occur after:

- Successful completion of the PSO onboarding process.
- TMHP provides written approval of the EVV proprietary system.
- TMHP and the PSO agree on a system transfer effective date.

Providers or FMSAs who transfer from the state provided EVV system to an EVV proprietary system or PSOs who transfer from one EVV proprietary system to another:

- Must make sure all staff, service providers and CDS employers complete EVV system training before using the new EVV proprietary system.
- CDS employers must make sure their employees complete EVV system training before using the new EVV proprietary system.
- Will not receive a grace period for complying with EVV Policy.
- May have EVV claims denied or recouped.

Are the EVV Systems accessible for people with disabilities?

The EVV vendor provides an accessible system, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the state provided EVV system, the state provided EVV system vendor will determine if an accommodation can be provided. However, state provided EVV system 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 EVV proprietary 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 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.

HHSC has approved three clock in and clock out methods:

- Mobile method
- Home phone landline
- Alternative device

A proprietary system operator (PSO) must offer one or more of the three HHSC-approved clock in and clock out methods listed above. If the PSO only offers one clock in and clock out method, it must be the mobile method.

The state provided EVV system vendor must provide access to all approved clock in and clock out methods at no cost to the member, program provider, FMSA, CDS employer, service provider, HHSC, MCO or TMHP, except for alternative devices as described in the EVV Policy Handbook, section 7040, Alternative Device.

1. Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
  - The Service Provider's personal smart phone or tablet; or

- A smart phone or tablet issued by the Provider or FMSA.

◦ 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
- A smart phone or tablet owned by the CDS employer, if permission is granted; or
- A smart phone or tablet purchased by the CDS employer for the CDS employee's use.
  - If the mobile method is offered as a clock in and clock out method, the state provided EVV system vendor or EVV proprietary system vendor will supply a downloadable application for use on a smartphone or device with internet connectivity.
  - The EVV allowed geo-perimeter is within 250-1320 feet of the member's home. The state provided EVV system vendor or EVV proprietary system vendor may select a geo-perimeter that meets their business needs if that geo-perimeter falls within the EVV allowed distance.
- If a service provider or CDS employee clocks in or clocks out within the geo-perimeter selected by the state provided EVV system vendor or PSO, the default service delivery location is the member home. The member home is the physical address where a member who receives EVV services resides. The service provider or CDS employee can select a different service delivery location if necessary.
- If the service provider or CDS employee clocks in or clocks out beyond the geo-perimeter selected by the state provided EVV system vendor or the PSO, the service provider or CDS employee must select a service delivery location.
- Service Delivery Location options include:
  - Member Home
  - Family Home
  - Neighbor's Home
  - Community
- 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.

2. Home phone landline

◦ A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System. A voice over internet protocol (VOIP) phone, is also allowable if it is a dedicated phone that requires fixed equipment at a specific address.

◦ To use a home phone landline, a Service Provider or CDS Employee must call the state provided EVV system vendor or PSO's toll-free number to clock in and clock out.

◦ If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.

- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

3. Alternative device

- An alternative device is an approved electronic device that allows a Service Provider or CDS Employee to clock in and clock out of the EVV system from the Member's home.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes from the state provided EVV system vendor are active for only seven days after the date of service and must be entered into the state provided 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.
- Per EVV Policy Handbook, section 7040, Alternative Device, HHSC limits the number of free alternative devices each provider and FMSA may order from the state provided EVV system vendor for assignment to the member.

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 or CDS Employee 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 FMSA, or CDS Employer must manually enter the visit in the EVV System using visit maintenance .
- If a Service Provider or CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider FMSA, or CDS Employer must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- Either the FMSA or the CDS employer will perform visit maintenance to correct the CDS Employee's visit transaction in accordance with the CDS Employer's selection on Form 1722.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV Visit Maintenance

Is there a timeframe in which Providers, FMSAs, CDS Employers, and Proprietary System Operators (PSOs) must perform Visit Maintenance?

In general, a Provider, FMSA, CDS Employer, or PSO 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: HHSC may extend the visit maintenance timeframe as needed.

Are Providers, FMSAs, CDS and PSOs 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 overall issue for the need to complete Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) provides more detail about why the Provider, FMSA, CDS Employer, or PSO completed Visit Maintenance.
- Free text is additional information the provider, FMSA CDS Employer or PSO must, if applicable, enter to further describe the need for Visit Maintenance.

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 state provided EVV system 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 system 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 state provided EVV system 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 state provided EVV system 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.
- The CDS employer must keep up-to-date training records of their training completions and provide training records to their FMSA, HHSC or their MCO, if requested.

For training resources, visit the **Dell Children's Health Plan EVV page.**

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 Landline Phone Verification Review - ensure valid phone type is used.
    - EVV Alternative Device Usage Reviews – ensure percent of EVV visit transactions recorded with an alternative device is within the allowable percentage per the alternative device reduction schedule.

For EVV compliance requirements and other information about EVV, visit **DellChildrensHealthPlan.com/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 EVV claims submission and corrected or adjusted claims, visit **DellChildrensHealthPlan.com/electronic-visit-verification/.**

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 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.
- The EVV Aggregator will still perform the claims match process between the EVV claim line item and the EVV visit transaction to record the actual claims match results. Providers and FMSAs can view the actual claim match results in the EVV Portal to find out if the claim would have matched without the bypass.
- The MCO may recoup the EVV claim , if the Provider, FMSA, or PSO does not follow the MCO's instructions related to claims match result code of EVV07 or EVV08.

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

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

A job aid for Accessing the EVV Portal for Providers and FMSAs is available **here.**

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.

Alternative Device Reduction Policies

HHSC is limiting the number of visit transactions that a program provider (including

those approved as a proprietary system operator (PSO)) or CDS employer may make using an alternative device. Beginning Sept. 1, 2028, going forward, a program provider, a program provider approved as a PSO or a CDS employer must limit the number of visit transactions made using an alternative device to 5% of their total visit transactions.

The reduction of the use of alternative devices will be implemented over a three year period beginning Sept. 1, 2025, and measured on a quarterly basis. The schedule for reducing alternative device usage is:

Fiscal year	Begin date	End date	Allowable % of Visit Transactions Made With an Alternative Device
2026	9/1/2025	8/31/2026	75%
2027	9/1/2026	8/31/2027	50%
2028	9/1/2027	8/31/2028	25%
2029	9/1/2028	Forward	5%

Beginning Sept. 1, 2025, program providers, program providers approved as a PSO, and CDS employers must not use the alternative device method for more than 75% of their EVV visit transactions per quarter.

Dell Children's Health Plan will monitor for compliance with the EVV alternative device standards on a quarterly basis. A program provider approved as a PSO or CDS employer who exceeds the allowable percentage of EVV visit transactions during a quarter using an alternative device may be subject to sanctions, up to and including contract termination or removal from the CDS Option.

Informational compliance reviews for alternative device usage will begin with Quarter 1 of fiscal year 2026 (covering September, October, and November 2025).

Dell Children's Health Plan will not take any enforcement action based on the Quarter 1 and Quarter 2 informational compliance reviews. Beginning in Quarter 3 of fiscal year 2026 (covering March 2026, April 2026 and May 2026), Dell Children's Health Plan may take enforcement action against any program provider, program provider approved as a PSO or CDS employer who exceeds the allowable percentage of EVV visit transactions during the review quarter.

Program providers and program providers approved as a PSO may want to look at ways to reduce alternative device usage such as purchasing other mobile devices as backup methods that can support the EVV system mobile application.

CDS employers may want to look into purchasing mobile devices that can support the EVV system mobile application their FMSA uses to record their EVV visits. As a reminder, CDS employers have the option to use part of their budget for CDS employee equipment expenses.

Chapter 15: **Pharmacy services**

Overview

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

For questions related to the formulary, the preferred drug list, billing, prescription overrides, prior authorizations, quantity limit or formulary exceptions, call Navitus at **1-877-908-6023** or access the Navitus website at **navitus.com.**

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

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

Prescription limits

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

CHIP member prescriptions

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

Office of Inspector General (OIG) Lock-In program

The HHSC OIG Lock-In program restricts, or locks in, a Medicaid member to a designated pharmacy if it finds that the member used drugs covered by Medicaid at a frequency or in an amount that is duplicative,

excessive, contraindicated or conflicting, or that the member's actions indicate abuse, misuse or fraud. Some circumstances allow a member to be approved to receive medications from a pharmacy other than the lock-in pharmacy. A pharmacy override occurs when Navitus approves a member's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. In order to request a pharmacy override, the member or pharmacy should call Navitus at **1-877-908-6023**. The following are allowable circumstances for pharmacy override approval:

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

Covered drugs

The Dell Children's Health Plan pharmacy program utilizes the Texas Medicaid/CHIP Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL). The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories, reviewed and approved by the Drug Utilization Review Board. Please refer to the VDP formulary and PDL at **txvendordrug.com.**

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

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered. Venosets, catheters and other medical accessories are not covered and are not included when submitting claims for intravenous and irrigating solutions.

Except for vitamins K and D3, prenatal vitamins, fluoride preparations and products containing iron in its various salts, we do not reimburse for vitamins or legend and non-legend multiple-ingredient anti-anemia products. Vitamins and minerals for members under age 21 are reimbursable.

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

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices

- Compounded medication of which at least one ingredient is a legend drug and listed on the PDL
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the VDP formulary
- PDL-listed legend contraceptives
    - **Exception:** Injectable contraceptives may be dispensed up to a 90-day supply.

You may also verify covered items at navitus.com or by calling **1-877-908-6023**.

Specialty drug program

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

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

Excluded drugs

The following drugs are excluded from the pharmacy benefit:

- Any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program, in accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8
- Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8, such as:
    - Weight control products (except orlistat, which requires prior authorization)
    - Drugs used for cosmetic reasons or hair growth
    - Experimental or investigational drugs
    - Drugs used for experimental or investigational indication
    - Infertility medications
    - Erectile dysfunction drugs to treat impotence
- Non-legend drugs other than those listed above or specifically listed under Covered non-legend drugs

Prior authorization

Navitus processes pharmacy prior authorizations (PA) for Dell Children's Health Plan. The formulary, prior authorization criteria and the length of the prior authorization approval are determined by the Health

and Human Services Commission (HHSC). Information regarding the formulary and the specific prior authorization criteria can be found at txvendordrug.com, ePocrates and SureScripts for ePrescribing. Prescribers can access prior authorization forms online at navitus.com under the Providers section or have them faxed by Customer Care to the prescriber's office. Prescribers will need to provide their NPI and state to access the portal. Completed forms can be faxed 24/7 to Navitus at **920-735-5312**.

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

Emergency prescription supply

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

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

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

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

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

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

Durable medical equipment/other products normally found in a pharmacy

Dell Children's Health Plan reimburses for covered durable medical equipment (DME) and products

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), pharmacies must be enrolled as DME providers and submit claims for most DME to Dell Children's Health Plan as a medical benefit; however, the durable medical supplies included in the VDP list of limited home health supplies can be submitted to Navitus as a pharmacy benefit.

To be reimbursed for DME under the pharmacy benefit, a pharmacy must first enroll in the Navitus network by contacting Navitus at **1-608-298-5775** or via email at **providerrelations@navitus.com.** For all other DME, the provider must be enrolled in the Dell Children's Health Plan network by contacting Network Development at **shpnetworkdevelopment@seton.org.**

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

Chapter 16: **Texas Department of Family and Protective Services**

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

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

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

Chapter 17: **Provider complaints and appeals process**

Provider complaint process

Dell Children's Health Plan maintains a system for tracking and resolving provider complaints pertaining to administrative issues and nonpayment-related matters other than Adverse Benefit Determinations. Dell Children's Health Plan accepts provider complaints orally, via mail, fax and email. Oral complaints may be submitted through the provider services line at **1-844-781-2343 (TTY 7-1-1)** or through your assigned Provider Relations Liaison. Written provider complaints should be submitted to:

Dell Children's Health Plan
Attn: Complaints
PO Box 37502
Oak Park, MI
48237-0502

Written complaints may also be faxed to **512-855-4909** or sent by email to **DCHPComplaints@ascension.org**. When submitting complaint information, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the complaint is resolved.

Dell Children's Health Plan will acknowledge complaints in writing within 5 business days of receipt and investigate and respond to all complaints within 30 calendar days from the date the complaint was received.

If a provider is not satisfied with the resolution of the complaint by Dell Children's Health Plan, that provider may complain to the state. A complaint to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response from Dell Children's Health Plan.

STAR complaints may be sent to:

Texas Health and Human Services Commission
Health Plan Management
Mail Code H-320
PO Box 85200
4900 N. Lamar
Austin, TX 78708-5200
Providers may also file a complaint with HHSC via email at: **HPM_Complaints@hhsc.state.tx.us**

Providers with a CHIP/CHIP Perinatal related complaint should submit those to TDI rather than HHSC at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
Fax: (512) 475-1771
Web: **tdi.texas.gov**
Email: **ConsumerProtection@tdi.state.tx.us**

Provider payment appeals

Dell Children's Health Plan offers providers a payment appeal resolution process. A payment appeal is any claim payment disagreement between the health care provider and Dell Children's Health Plan for reasons including but not limited to:

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

Responses to itemized bill requests, submission of corrected claims and submission of coordination of benefits/third-party liability information are not considered payment appeals. These are considered correspondence and should be addressed to claims correspondence (see the billing and claims administration chapter for more information).

No action is required by the member. Provider payment appeals do not include member medical appeals.

Providers may make the initial attempt to resolve a claim issue by calling Provider Services at **1-844-781-2343 (TTY 7-1-1)** or a provider relations representative. Providers will not be penalized for filing a payment appeal. All information will be confidential. The payment appeals team will receive, distribute and coordinate all payment appeals. To submit a payment appeal, please complete the payment appeal form located online at **DellChildrensHealthPlan.com** and submit it to:

Dell Children's Health Plan
Attn: Appeals
PO Box 37502
Oak Park, MI
48237-0502

Providers may also utilize the payment appeal tool at **secure.healthx.com/Provider_2022.** When inquiring on the status of a claim that is considered eligible for appeal due to no or partial payment, a button will display for submission of an appeal. Once this button is clicked, a web form will display for the provider to complete and submit. If all required fields are completed, the provider will receive immediate acknowledgement of his or her submission. When using the online tool, supporting documentation can be uploaded using the attachment feature on the web form. The documentation will

attach to the form when submitted.

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

- Letter stating the reason(s) why the provider believes the claim reimbursement is incorrect
- Copy of the original claim
- Copy of the Dell Children's Health Plan EOP
- EOP or EOB from another carrier
- Evidence of eligibility verification (e.g., a copy of ID card, panel report, the TMHP/TexMedNet documentation, call log record with the date and name of the Dell Children's Health Plan person the provider's staff spoke with when verifying eligibility)
- Medical records
- Approved authorization forms from us indicating the authorization number
- Contract rate sheets indicating evidence of payment rates
- Evidence of previous appeal submission or timely filing
- Certified or overnight mail receipt with the claim or appeal log if more than one claim or appeal was submitted
- EDI claim transmission reports indicating that the claim was accepted by Dell Children's Health Plan
    - **Note:** Rejection reports are not accepted as proof of timely filing.

When submitting a payment appeal, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the appeal is resolved.

The payment appeals team will research and determine the current status of a payment appeal. A determination will be made based on the available documentation submitted with the appeal and a review of Dell Children's Health Plan systems, policies and contracts. Payment appeals received with supporting clinical documentation will be retrospectively reviewed by a registered/licensed nurse. Established clinical criteria will be applied to the payment appeal. After retrospective review, the payment appeal may be approved or forwarded to the plan medical director for further review and resolution.

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

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

If a provider is dissatisfied with the Level I payment appeal resolution, he or she may file a second-level payment appeal. This must be a written appeal and must be submitted within 30 days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. Once the appeal is reviewed, the results will be communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. An EOP is used to notify providers of overturned denied claims or additional payments. An upheld denied claim receives a payment appeal determination letter. For a decision in which the denial was upheld, the provider should review the Participating Provider Agreement for any other available methods of dispute resolution. The provider may also file a complaint with HHSC or TDI as applicable.

Questions regarding the Dell Children's Health Plan two-level provider payment appeal process may be directed to Provider Services or a Provider Relations representative.

Provider appeal process to HHSC (related to claim recoupment due to member disenrollment)

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

- A letter indicating the appeal is related to a managed care disenrollment/recoupment and the provider is requesting an exception request.
- **The explanation of benefits (EOB) showing the original payment**. **Note:** This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's demand letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and taxonomy number. **Note**: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
PO Box 204077
Austin, TX 78720-4077

Provider appeal process to TDI (for CHIP members)

If a CHIP member or the member's representative is not satisfied with the outcome of Dell Children's Health Plan's appeal process, they can file a complaint with the Texas Department of Insurance (TDI). The member can contact TDI by calling toll free **1-800-252-3439** or in writing to:

Consumer Protection, MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

The CHIP member can also submit their complaint online at **www.tdi.texas.gov**.

Chapter 18: **Claim processing related overpayments**

DCHP through its contractual arrangement with ABS, will process overpayments to providers by meeting the HHSC requirements documented in the UMCM and HHSC contract. This policy and procedure does not cover SIU/FWA cases processed by ABS and in coordination with HHSC-OIG.

Procedure for identification and processing overpayments:

- ABS processes claims for DCHP and therefore, is responsible for identification and recovery of overpayments to providers. Overpayments are a result of many factors, including but not limited to:
    - Claim processing errors
    - Retro fee schedule adjustment from TMHP/HHSC
    - Retro contract changes
    - Provider identified overpayments
    - ABS identified overpayments through monthly queries such as, but not limited to:
        - Eligibility changes (retro member terms)
        - Configuration changes resulting in overpayments
        - Audits of claims – audits/identification must be completed timely so that providers are notified (overpayment letter 1) no later than 24 months of receipt of original claim
- Once identification of an overpayment is made, ABS will do the following:
    - Send the provider a letter requesting payment be made to DCHP within sixty (60) days of the letter
    - If payment is received within 60 days of the letter, ABS will adjust the claim accordingly:
        - Close the overpayment because it was paid in full or,
        - Notify the provider they have a balance due through Overpayment Letter 2 if they did not pay the full amount
    - If no payment has been received within 60 days from the letter, ABS will start the auto recovery process to offset amount owed from future claims payments made by ABS to the provider.

Procedure for auto-recovery of overpayments from providers

- If a provider does not make payment as requested from Overpayment letters (process above), the auto-recovery process will begin. The following describes the process for completion:

- ABS will set up a system code to stop future payment to providers until the amount owed can be offset against future claims coming in from providers.
- If ABS does not have enough claims to offset amounts owed by the provider within 149 days, the amount owed may be sent to the recovery vendor on day 150 to pursue directly with the provider.
- NOTE: This auto-recovery process was put on hold in 2024 due to other issues impacting the ability for ABS to off-set these overpayments on future claims.

Appeals for overpayment

- Providers may appeal an overpayment request from DCHP like any other claims appeal and with the same process outlined in the provider manual. Providers can either request an appeal through the claim appeal process on the provider portal (there is a box they can check for overpayment related appeals) or by putting the request in writing to DCHP/ABS.

  Dell Children's Health Plan
  PO Box 37502
  Oak Park, MI 48237-0502

- Refer to claim appeals policy & procedure for complete process.

Chapter 19: **Member complaint and appeal process**

Overview

Medicaid and CHIP members or their representatives may contact a member advocate or Member Services Representative for assistance with writing or filing a complaint or appeal (including an expedited appeal). The member advocate also works with the member to monitor the process through resolution.

Definitions

Adverse Benefit Determination: The denial or limited authorization of a requested service, including:

- Type and level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment of service
- Failure to provide services in a timely manner as determined by the State
- Failure of the contractor to act within certain time frames
- Denial of a Medicaid member's request to exercise his or her right to obtain services outside the network (for a resident of a rural area with only one managed care organization)
- The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities

Medical appeals are addressed in the medical appeal process and procedures section of this chapter.

Appeal (Medicaid only): The formal process by which a member or his or her representative requests a review of the health plan's Adverse Benefit Determination.

Appeal (CHIP only): The formal process by which Dell Children's Health Plan or a utilization review agent addresses the health plan's Adverse Benefit Determinations.

Appellant: Any member or other person or agency acting on behalf of the member who files an appeal.

Complainant: Member or a treating provider or other individual designated to act on behalf of the Member who filed a Complaint.

Complaint (CHIP): Any dissatisfaction expressed by a complainant (orally or in writing) to the health plan with any aspect of the health plan's operation, including but not limited to:

- Plan administration
- Procedures related to review or appeal of an adverse determination

- Denial, reduction or termination of a service for reasons not related to medical necessity
- Service delivery/provision
- Disenrollment decisions

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

Complaint (Medicaid): An expression of dissatisfaction (orally or in writing) to the health plan about any matter related to the health plan other than an Adverse Benefit Determination as defined in this section. Possible subjects for complaints include:

- Quality of care or services provided
- Aspects of patient interaction, such as rudeness of a provider or employee
- Failure of provider or employee(s) to respect a member's rights regardless of whether remedial action is requested.
- Complaint includes the Member's right to dispute an extension of time (if allowed by law) proposed by the health plan to make an authorization decision.

Initial Contact Complaint: A complaint that is resolved within one Business Day.

Member complaint process

Complaint process (STAR Medicaid)

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at **1-855-921-6284 (TTY 7-1-1)** to tell us about your problem. A Dell Children's Health Plan Member Services representative or a Member Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days. Dell Children's Health Plan cannot take any action against you as result of you filing a complaint.

Can someone from Dell Children's Health Plan help me file a complaint?

Yes, a Member Advocate or a Member Services representative can help you file a complaint with Dell Children's Health Plan or with the appropriate state agency. Please call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

How long will it take to process my complaint?

Dell Children's Health Plan will answer your complaint within 30 calendar days from the date we get it.

What are the requirements and timeframes for filing a complaint?

You can tell us about your complaint by calling us at **1-855-921-6284 (TTY 7-1-1)** or writing us at

Dell Children's Health Plan
Attn: Complaints Specialist
1345 Philomena St., Suite 305
Austin, TX 78723.

We will send you a letter within five business days of getting your complaint. This means that we received your complaint and have started to look at it. The letter will contain the description of Dell Children's Health Plan's complaint process and timeframes for processing. We may call you to get more information.

Dell Children's Health Plan will investigate the complaint and will send you a resolution letter within 30 calendar days following the receipt of the complaint. This letter will tell you what we have done to address your complaint. The complaint resolution letter includes the process to appeal the decision when the member or member's representative is not satisfied with Dell Children's Health Plan response.

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive your complaint.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Dell Children's Health Plan complaint process?

If you are a Medicaid member, once you have gone through the Dell Children's Health Plan complaint process, if you are not satisfied with the answer to your complaint, you can file a complaint with the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**. If you would like to file your complaint in writing, please send it to the following address:

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

If you can get on the internet, you can send your complaint using the following form at **hhs.texas.gov/omcat**.

Do I have the right to make a complaint appeal?

Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal in writing. Write to us at:

Dell Children's Health Plan
Attn: Complaints Specialist
1345 Philomena St., Ste. 305
Austin, TX 78723

When we get your request, we'll send you a letter within five business days. This means that we have your request and started to work on it. You can also call us at **1-855-921-6284 (TTY 7-1-1)** to ask for a complaint appeal.

We will send you a letter within 30 calendar days of getting your request. The letter will tell you the complaint appeal decision. This letter will also give you the information used to make its decision.

Complaint process (CHIP)

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at **1-855-921-6284 (TTY 7-1-1)** to tell us about your problem. A Dell Children's Health Plan Member Services representative or a Member Advocate can help you file a complaint. Just call **1-855-921-6284 (TTY 7-1-1)**. Most of the time, we can help you right away or at the most within a few days. Dell Children's Health Plan cannot take any action against you as a result of your filing a complaint.

Can someone from Dell Children's Health Plan help me file a complaint?

Yes. A Dell Children's Health Plan Member Advocate or a Member Services Representative can help you file a complaint with us or the appropriate state agency. Please call Member Services at **1-855-921-6284 (TTY 7-1-1).**

How long will it take to process my complaint?

Dell Children's Health Plan will answer your complaint within 30 calendar days from the date we received it.

What are the requirements and timeframes for filing a complaint?

You can tell us about your complaint by calling us at **1-855-921-6284 (TTY 7-1-1)** or writing us at

Dell Children's Health Plan
Attn: Complaints Specialist
1345 Philomena St., Suite 305
Austin, TX 78723

We will send you a letter within five business days of getting your complaint. This means we have your complaint and have started to look at it. The letter will contain the description of Dell Children's Health Plan's complaint process and timeframes. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

How long will it take to process my complaint?

Dell Children's Health Plan will answer your complaint within 30 days from the date we get it. If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive your complaint.

If I am not satisfied with the outcome, who else can I contact?

If you are a CHIP/CHIP Perinatal member, once you have gone through the Dell Children's Health Plan complaint process, and if you are not satisfied with the answer to your complaint, you can file a complaint with the Texas Department of Insurance by calling **1-800-252-3439 toll-free**. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection, MC: CO-CP
PO Box 12030
Austin, TX 78711-2030

If you can get on the internet, you can send your complaint in an email at ConsumerProtection@tdi.texas.gov. Or completing the complaint form found at www.tdi.texas.gov.

Do I have the right to make a complaint appeal?

Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal in writing at:

Dell Children's Health Plan
Complaints Specialist
1345 Philomena St., Ste. 305
Austin, TX 78723

When we get your request, we'll send you a letter within five business days. This means that we have your request and started to work on it. You can also call us at **1-855-921-6284 (TTY 7-1-1)** to ask for a complaint appeal.

We will send you a letter within 30 calendar days of getting your written request. The letter will tell you the complaint appeal decision. This letter will also give you the information used to make its decision.

Member medical appeal process and procedures

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

Note: Medical appeals do not apply to non-medical issues. Non-medical concerns are classified as complaints.

Appeal process (STAR Medicaid)

What can I do if my doctor asks for a service or medicine for me that's covered but Dell Children's Health Plan denies it or limits it?

There may be times when Dell Children's Health Plan says it will not pay for or cover all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Dell Children's Health Plan to look again at the care your doctor asked for and we said we will not pay for. You can appeal our decision in 3 ways:

- You can call Member Services at **1-855-921-6284**
- You can fill out the **Appeal Request Form**, included in the denial letter.
- You can send us a letter to:
  Dell Children's Health Plan Appeals
  1345 Philomena St., Ste 305
  Austin, TX 78723.

How will I find out if services are denied?

If we deny services, we will send you a letter at the same time the denial is made.

What are the time frames for the appeals process?

You or a designated representative can file an appeal. You must do this within 60 days of the date of the first letter from Dell Children's Health Plan saying we will not pay for or cover all or part of the recommended care.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Dell Children's Health Plan to let us know you have chosen a person to represent you. Dell Children's Health Plan must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

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

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

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

How can I continue receiving services that were already approved?

To continue receiving services that have already been approved by Dell Children's Health Plan but may be part of the reason for your appeal, you must file the appeal on or before the later of:

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

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

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

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

Can someone from Dell Children's Health Plan help me file an appeal?

Yes, a member advocate or Member Services representative can help you file an appeal with

Dell Children's Health Plan or the appropriate state program. Please call Member Services toll-free at **1-855-921-6284 (TTY 7-1-1)**.

Can members request a state fair hearing?

Yes, you have the option to ask for a state fair hearing and external medical review, or you can request only a state fair hearing. The request must be received no later than 120 days after the appeal decision notice is mailed, and can be requested at any time during or after the appeals process.

Process to appeal a CHIP adverse determination

What can I do if my child's doctor asks for a service or medicine for my child that is covered, but Dell Children's Health Plan denies or limits it?

There may be times when Dell Children's Health Plan says we will not pay for all or part of the recommended care You have the right to ask for an appeal. An appeal is when you or a person on your behalf asks Dell Children's Health Plan to look again at the care your child's doctor asked for and we said we will not pay for. You can appeal our decision two ways:

- Call Member Services at **1-855-921-6284 (TTY 7-1-1)**
- Send us a letter to:

  Dell Children's Health Plan
  Attn: Appeals
  1345 Philomena St., Ste. 305
  Austin, TX 78723

You can have someone else help you with the appeal process. This person can be a family member, friend, your doctor or any other person you know.

How will I find out if services are denied?

If we deny services, we will send you a letter at the same time the denial is made.

What are the time frames for the appeal process?

You can file an appeal within 180 days of the date on the first letter from Dell Children's Health Plan saying we will not pay for all or part of the recommended care.

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

A doctor who has not seen your case before will look at your appeal. We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal.

If you are not happy with the answer to your first-level appeal, you can ask your child's doctor to ask us to look at the appeal again. This is called a specialty review. Your child's doctor must send us a letter to ask

for a specialty review within 10 business days of the date on the first appeal decision letter from Dell Children's Health Plan.

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

When do I have the right to ask for an appeal?

You must request an appeal within 180 days from the date on the first letter from Dell Children's Health Plan that says we will not pay all of part of the service. If you, the person acting on your behalf, or the provider are not happy with the answer to your first appeal, the doctor must send us a letter to ask for a specialty review. This letter must be sent within 10 business days from the date on our letter with the answer to your first appeal.

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

Does my request have to be in writing?

No. You can request an appeal by calling Member Services at **1-855-921-6284 (TTY 7-1-1)**.

Can someone from Dell Children's Health Plan help me file an appeal?

You can call Member Services at **1-855-921-6284 (TTY 7-1-1)** if you need help filing an appeal.

Expedited medical appeal

An expedited medical appeal will be performed when appropriate. A member can request an expedited medical appeal in cases where time expended in the standard resolution could jeopardize the member's life, health or ability to attain, maintain or regain maximum function. An expedited medical appeal concerns a decision or action by Dell Children's Health Plan that relates to:

- Health care services including, but not limited to, procedures or treatments for a member with an ongoing course of treatments ordered by a health care provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life
- A treatment referral, services, procedure or other health care service that if denied could significantly increase risk to a member's health or life

What is an expedited appeal?

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

How do I ask for an expedited appeal? Does my request have to be in writing?

You or the person you ask to file an appeal for you can request an expedited appeal. You can request an expedited appeal orally or in writing:

- You can call Member Services at **1-855-921-6284 (TTY 7-1-1)**.
- You can send us a letter to:
  Dell Children's Health Plan
  Attn: Appeals
  1345 Philomena St., Ste. 305
  Austin, TX 78723

What are the time frames for an expedited appeal?

For Medicaid members:

After we get your letter or call and agree your request for an appeal should be expedited, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

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

For CHIP members:

After we get your letter or call and agree your request for an appeal should be expedited, we will tell you our decision within one business day from receipt of your appeal request. We will let you know by phone or electronically and written notice will also be sent within three business days.

What happens if Dell Children's Health Plan denies the request for an expedited appeal?

If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

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

Who can help me file an expedited appeal?

A member advocate or Member Services representative can help you file an expedited appeal. Please call Member Services toll-free at **1-855-921-6284 (TTY 7-1-1)**.

For CHIP members, if your child has a life-threatening condition or we deny prescription drugs or intravenous infusions that are already being received, you or someone acting on your behalf or the provider can ask for an immediate review by an independent review organization. You do not have to go through the Dell Children's Health Plan internal appeal process first.

External Review Process

For CHIP members

CHIP external review (independent review)

External review: If you disagree with our decision about your appeal and the decision involved medical judgment, then you have the right to ask for an external review by an independent third party. You, a person acting on your behalf, an attorney, or your provider can ask for an external review within 4 months of getting the appeal decision.

How to request an external review?

Maximus Federal Services, Inc. is the independent review organization that will conduct the external review. You can use forms from Maximus to ask for an external review or send a written request, including any additional information for review. You can get the Maximus forms by calling Member Services, Maximus at **1-888-975-1080** or online at **maximusferp.my.site.com/FERP/s/forms.**

Fill out one or both of the Maximus forms based on who will ask for the external review. Complete:

- The HHS-Administered Federal External Review Request Form to request an external review yourself.
- Both the HHS-Administered Federal External Review Request Form and the Appointment of Representative Form if you want your provider or another person to ask for the external review for you.

Or, send a written request with:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Signature of member, parent or legal guardian, or authorized representative
- A short description of the reason you disagree with our decision
- **Send your forms or written request to us at:**

  Dell Children's Health Plan
  Medical Management
  1345 Philomena St., Ste. 305
  Austin, TX 78723

- Fax: **512-380-4253**
- Email: **dchp-UM@ascension.org**

You can also send your request directly to Maximus by one of the ways below:

- Online: **maximusferp.my.site.com/FERP/s/requestreview** under the "Request a Review Online" heading

- Mail:
  MAXIMUS Federal Services
  3750 Monroe Ave., Ste. 708
  Pittsford, NY 14534
- Fax: **1-888-866-6190**

If you send additional information to Maximus for the review, it will be shared with Seton Health Plan so that we can reconsider the denial. If you have questions during the external review process, contact Maximus at **1-888-975-1080** or go to **maximusferp.my.site.com/FERP/s/**.

You can ask for an expedited external review:

- If you asked for an expedited appeal after our initial denial and waiting up to 72 hours would seriously jeopardize your life, health or ability to regain maximum function, you can request an expedited external review at the same time
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize your life, health or ability to regain maximum function
- If the appeal decision is about an admission, availability of care, continued stay, or health-care service for which emergency services were received but the member has not been discharged from the facility

How to request an expedited external review

- Online: you can select "expedited" when submitting the review request, or
- Email: **FERP@maximus.com**, or
- Call: Federal External Review Process at **1-888-975-1080**

If you file an appeal or ask for an external review, we will not hold it against you, or your provider.

CHIP members must complete the first level of the Dell Children's Health Plan appeal process resulting in an adverse decision prior to filing a request for a review by an independent review organization (IRO), except in the case of a life-threatening condition or a denial for prescription drugs or intravenous infusions already being received. The member (or person acting on behalf of the member) can request an IRO hearing by submitting the IRO form attached to the appeal letter to:

Dell Children's Health Plan
Attn: IRO Appeals
1345 Philomena St., Ste. 305
Austin, TX 78723

What are the timeframes for this process?

The IRO will send a decision letter to you by the earlier of:

- 20 days from the date the IRO received the request for an independent review.
- 15 days from the date the IRO received all information needed to make a decision.

In the case of a life-threatening condition, the IRO will contact you with its decision by phone and also send you written notification within three days of the IRO's receipt of the request for independent review.

For STAR Medicaid members

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 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose his or her right to an external medical review. To ask for an external medical review, the member or the member's representative should either:

- Fill out the State Fair Hearing and External Medical Review Request Form provided as an attachment to the member notice of internal appeal decision letter and mail or fax it to Dell Children's Health Plan by using the address or fax number at the top of the form;
- Call Dell Children's Health Plan at **512-324-3013 (TTY 7-1-1)** or **1-855-962-4453 (TTY 7-1-1)**; or
- Email Dell Children's Health Plan at **dchp-UM@ascension.org**

If the member asks for an external medical review within 10 days from the time the member gets the appeal decision from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The member, the member's authorized representative, or the member's LAR may withdraw the member's request for an external medical review before it is assigned to an independent review organization or while the independent review organization is reviewing the member's external medical review request. The member, the member's authorized representative, or the member's LAR must submit the request to withdraw the external medical review using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An independent review organization is a third party organization contracted by HHSC that conducts an external medical review during member appeal processes related to adverse benefit determinations based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an independent review organization has already completed the review and made a decision.

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

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. The member may withdraw a state fair hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a state fair hearing and the state fair hearing decision is different from the independent review organization decision, the state fair hearing decision is final. The state fair hearing decision can only uphold or increase member benefits from the independent review organization decision.

Can a member ask for an emergency external medical review?

If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency external medical review and emergency state fair hearing by writing or calling Dell Children's Health Plan. To qualify for an emergency external medical review and emergency state fair hearing the member must first complete Dell Children's Health Plan internal appeals process.

State fair hearing

Can a member ask for a state fair hearing?

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for a state fair hearing. The member may name someone to represent them by contacting the health plan and giving the name of the person the member wants to represent him or her. A provider may be the member's representative if the provider is named as the member's authorized representative. The member or the member's representative must ask for the state fair hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should either call or send a letter to Dell Children's Health Plan at:

- Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- Phone: **512-324-3013 (TTY 7-1-1)** or **1-855-962-4453 (TTY 7-1-1)**, Monday through Friday, 8 a.m. to 5 p.m. Central time
- Email: **dchp-UM@ascension.org.**

If the member asks for a state fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the member does not request a state fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

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

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

Can I ask for an emergency state fair hearing?

If you believe that waiting for a state fair hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency state fair hearing by:

- Writing to:
  Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- Phone: **512-324-3013 (TTY 7-1-1)** or **1-855-962-4453 (TTY 7-1-1)**, Monday through Friday, 8 a.m. to 5 p.m. Central time
- Email: **dchp-UM@ascension.org.**

To qualify for an emergency state fair hearing through HHSC, you must first complete Dell Children's Health Plan's internal appeals process.

Chapter 20: **Member eligibility**

Overview

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

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

Verifying member Medicaid eligibility

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

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

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

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

We encourage all providers to verify eligibility and benefits before each service is rendered. Please call Dell Children's Health Plan provider services at **1-844-781-2343 (TTY 7-1-1)** or log on to our secure provider website to look up claims status, eligibility and authorizations at **secure.healthx.com/Provider_2022.**

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub—regardless of the plan (FFS or managed care). All of this information is collected and displayed in a consolidated form (health summary)

with the ability to view additional details if need be. It's free and requires a one-time registration.

To access the portal, visit **tmhp.com** and follow the instructions in the Initial Registration Guide for Medicaid Providers. For more information on how to get registered, download the Welcome Packet on the home page.

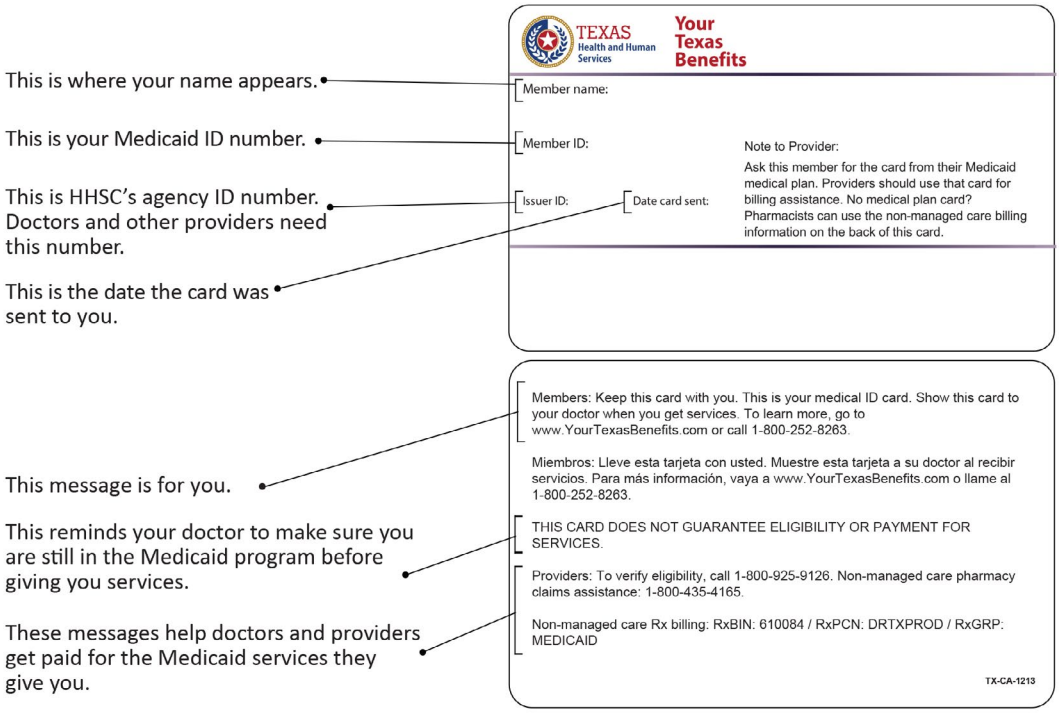
TexMedConnect allows providers to:

- View available health information such as:
  - Vaccinations
  - Prescription drugs
  - Past Medicaid visits
  - Health events, including diagnosis and treatment
  - Lab results
- Verify a Medicaid patient's eligibility and view patient program information
- View Texas Health Steps alerts
- Use the blue button to request a Medicaid patient's available health information in a consolidated format

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

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

Your Texas Benefits Medicaid card sample:



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

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

- Member's name and Medicaid ID number
- The date the card was sent to the member
- The name of the Medicaid program if the member gets:
    - Medicare (QMB, MQMB)
    - Healthy Texas Women Program
    - Hospice
    - STAR Health
    - Emergency Medicaid
    - Presumptive eligibility for pregnant women (PE)
- What a drugstore will need to bill Medicaid
- The name of the member's doctor and drugstore if the member is in the Medicaid Lock-in program

The back of the Your Texas Benefits Medicaid card has a website the member can visit YourTexasBenefits.com and a phone number they can call toll-free **1-800-252-8263** if there are questions about the card. State-issued ID cards are subject to change without notice.

Dell Children's Health Plan ID card sample:

Temporary ID verification form (Form 1027-A)

Providers must accept these documents as valid proof of eligibility. Providers should retain a copy for their records to ensure the person is eligible for Medicaid when the services are provided. Make a copy of both sides. Providers should request additional identification if they are unsure whether the person presenting

the form is the person identified on the form. Providers should check the eligibility date to see whether the client has possible retroactive coverage for previous bills. Current coverage can be verified as described in the verifying member medicaid eligibility section.
Members can also go online at YourTexasBenefits.com to order a new card or print a temporary card at hhs.texas.gov/regulations/forms/1000-1999/form-h1027-a-medicaid-eligibility-verification.

STAR

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

CHIP

Depending upon the member's CHIP category, the copays may vary. Preventive health care services, such as well-child exams and immunizations, are exempt from cost sharing.

We will issue a new ID card for those members who have notified the state of Texas that they have met the out-of-pocket annual maximum. The new member ID card will display zero dollars for copays.

Service responsibility

STAR service exception table

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

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

CHIP responsibility table

CHIP-eligible members receive coverage for up to 12 consecutive months and must apply for Medicaid if they are eligible. Most newborns born to CHIP members or CHIP heads of household will be Medicaid-eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP-eligible, the baby will be covered from the beginning of the month of birth for the period. Note: There is no spell-of-illness limitation for CHIP members.

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

CHIP Perinatal responsibility table

The CHIP Perinatal program provides certain prenatal and birth benefits to unborn children of pregnant women (adults or teens) not otherwise eligible for Medicaid due to income limits or their immigration status.

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

After delivery, newborns in families with income at or below the Medicaid eligibility threshold move from the CHIP Perinate program to Medicaid FFS, where they receive twelve months of continuous Medicaid coverage (beginning on the date of birth). Managed care will occur prospectively. An enrollment packet will be mailed to the household, and they will be given the opportunity to select an MCO of their choice. If no selection is made, HHSC will assign an MCO using the current default plan assignment process.

A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" after birth if the child's family income is above the Medicaid eligibility threshold. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal MCO. The family can submit an application for Medicaid for the newborn if they choose. If eligible, disenrollment from CHIP Perinatal will be coordinated with enrollment in Medicaid.

CHIP Perinate Newborns will have the same newborn benefits as those children enrolled in the regular CHIP program after the initial CHIP Perinate newborn admission. There is no spell-of-illness limitation for CHIP Perinate newborn members. Copays/cost sharing does not apply to CHIP Perinate mothers or CHIP Perinate newborns.

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

Member enrollment and disenrollment from Dell Children's Health Plan

Medicaid enrollment

Medicaid members may enroll in or disenroll from Dell Children's Health Plan at any time. If a member asks how to enroll in, or disenroll from Dell Children's Health Plan, the provider can direct the member to either method below:

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

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

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

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

Medicaid expedited enrollment of pregnant women

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

Certification date	Enrollment standard
Certified from the 11th through the end of the month	Member will be enrolled on the first day of the month following the month of certification
Certified at any time during their estimated month of delivery	Member will be enrolled the first day of the following month (prospective enrollment)
Certified in their actual month of delivery (if known by the Department of State Health Services prior to certification)	Member will be enrolled the first day of the following month (prospective enrollment)

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

Medicaid automatic re-enrollment

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

Medicaid managed care program disenrollment

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

Medicaid enrollment changes during an inpatient stay in a single hospital

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

Scenario	Hospital facility charge	All other covered services
Member retroactively enrolled in STAR	New MCO	New MCO
Member prospectively moves from FFS to STAR	Medicaid FFS	New MCO
Member moves between STAR MCOs	Former MCO	New MCO
Member moves from STAR to STAR Health	Former STAR MCO	New STAR Health MCO
Member moves from STAR to STAR+PLUS or Dual Demonstration	Former STAR MCO	New STAR+PLUS or Dual Demonstration MCO
Adult member moves from STAR Health to STAR	Former STAR Health MCO	New STAR MCO

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

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

Disenrollment from managed care during an inpatient stay in a hospital

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

Scenario	Hospital facility charge	All other covered services
Member moves from STAR to FFS (disenrolled at MCO's request)	Former STAR MCO	Medicaid FFS

Enrollment changes during a chemical dependency treatment facility stay

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

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

Scenario	CDTF charge	All other covered services
Member retroactively enrolled in STAR	New MCO	New MCO
Member prospectively moves from FFS to STAR	New MCO	New MCO
Member moves between STAR MCOs	Former MCO	New MCO
Member moves from STAR to STAR Health	Former STAR MCO	New STAR Health MCO
Adult member moves from STAR Health to STAR	Former STAR Health MCO	New STAR MCO
Member moves from STAR to STAR+PLUS or Dual Demonstration (based on change in SSI status)	Former STAR MCO	New STAR+PLUS or Dual Demonstration MCO

Disenrollment from managed care during a CDTF stay

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

Scenario	Hospital facility charge	All other covered services
Member moves from STAR to FFS (disenrolled at MCO's request)	Former STAR MCO	Medicaid FFS

Medicaid enrollment changes with custom DME and augmentative device prior authorization

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

Scenario	Custom DME	All other covered services
Member moves between STAR, STAR+PLUS or STAR Health MCOs	Former MCO	New MCO

Scenario	Custom DME	All other covered services
Member moves from FFS to STAR, STAR+PLUS or STAR Health MCO	New MCO	New MCO

STAR members enrolled in DADS hospice program

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

CHIP enrollment

Children who enroll in CHIP receive 12 months of continuous coverage. Members must re-enroll annually. If members need assistance with re-enrollment, direct them to call Dell Children's Health Plan Member Services at **1-855-921-6284 (TTY 7-1-1)** or CHIP at **1-800-964-2777**.

Dell Children's Health Plan CHIP disenrollment

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

- For any reason within 90 days of enrollment in CHIP
- For cause at any time
- If the member moves to a different service delivery area
- During the member's annual re-enrollment period

HHSC will make the final decision. Providers cannot take retaliatory action against a member who decides to disenroll from CHIP.

CHIP Perinate enrollment and disenrollment

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

CHIP Perinate plan change

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

Newborns born to CHIP Perinatal mothers who are certified for Medicaid at birth, will be placed in FFS and managed care enrollment will occur prospectively. An enrollment packet will be mailed to the household, and they will be given the opportunity to select an MCO. If no selection is made, HHSC will assign an MCO using the current default plan assignment process.

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

A CHIP Perinate unborn member will continue to receive coverage through the CHIP program as a CHIP Perinate Newborn if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.

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

If the mother of the CHIP Perinate member lives in an area with more than one CHIP MCO and does not select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinate, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinate member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinate member's enrollment period or (2) the end of the traditional CHIP members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP Perinate coverage expires, the child will be added to his or her siblings' existing CHIP case.

CHIP Perinate members may request to change health plans for any reason within 90 days of enrollment in the CHIP Perinate program, for cause at any time, and if the member moves into a different service delivery area.

CHIP Perinate disenrollment

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

Enrollments and disenrollments during hospital confinement

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

Effective date of SSI status

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

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

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

Chapter 21: **Member rights and responsibilities**

Medicaid member rights and responsibilities

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

STAR 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 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.

STAR 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 primary care provider quickly.
    - Make any changes in your health plan and primary care provider in 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 nonemergency medical needs.
    - Be sure you have the 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:
    - 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.

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 HHS Office of Civil Rights online at **hhs.gov/ocr.**

CHIP member rights and responsibilities

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

CHIP member rights

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

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

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

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

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

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

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

CHIP member responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.

6. If you make the appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers the copayments you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.

8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members or health plans.

9. Talk to your child's provider about all of your child's medications.

CHIP Perinate member rights and responsibilities

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

CHIP Perinate member rights

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

CHIP Perinate member responsibilities

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

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

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 HHS Office of Civil Rights online at **hhs.gov/ocr.**

Member's right to designate an obstetrician/gynecologist

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

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

Dell Children's Health Plan allows the member to pick an OB/GYN, but this doctor must be in the same network as the member's primary care provider.

ATTENTION FEMALE MEMBERS

Do I have the right to choose an OB/GYN?

Members have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

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

Member's right to report allegations of provider discrimination based on immunization status

You have the right to file a complaint regarding a provider discriminating against you based on immunization status. In accordance with H.B. 44, Medicaid providers are prohibited from refusing to provide healthcare services to any Medicaid client based solely on the client's refusal or failure to obtain a vaccine or immunization for a particular infectious or communicable disease unless accepted by Texas Government Code §531.02119."

Guidance for STAR Members

- Allegations of provider discrimination based on vaccine status are handled by HHSCC and not by Dell Children's Health Plan (MCO) or DMO, as applicable:
    - HHSC receives these allegations through the HHS Office of Ombudsman.
- Ways to reach the HHS Office of Ombudsman include:
    - Toll-free phone call to the Managed Care Assistance Team: **1-866-566-8989.** A person who has a hearing or speech disability, call 7-1-1 or **800-735-2989.**
    - Online at: **hhs.texas.gov/omcat**
    - Faxing toll-free to: **888-780-8099.**
    - Mailing to: Texas Health and Human Services Commission, Office of the Ombudsman, MC H-700, P.O. Box 13247, Austin, Texas 78711-3247.

Guidance for CHIP members

- You may submit allegations through the MCCO Research and resolution team using these methods below. This can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Section 1.7, "Provider Responsibilities", "Nondiscrimination for Vaccine Status" as of September 1st, 2024.
    - Complaint inbox: **HPM_Complaints@hhsc.state.tx.us**
    - Online Portal **texashhs.org/ManagedCareProviderComplaint**
    - Fax: **512-491-1958**
    - Mail: Health and Human Services Commission Medicaid/CHIP, Managed Care Compliance and Operations, P.O. Box 149030 MC-0210, Austin, Texas 78714-9030

Chapter 22: **Billing and claims administration**

Overview

Providers have three options for submitting claims to us:

- Electronic Data Interchange (EDI)
- Online provider portal
- Paper

Timely filing

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

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

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

Coding

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

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

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

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

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

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

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

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

Clean claim

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

a. 837 Professional Combined Implementation Guide

b. 837 Institutional Combined Implementation Guide

c. 837 Professional Companion Guide

d. 837 Institutional Companion Guide

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

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

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

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

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

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

Claims payment

Clean claims are adjudicated within 30 calendar days of receipt for both institutional and professional claims (18 days for electronic pharmacy claims submission and 21 days for non-electronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

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

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

Deficient claim

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

Claim submission

Electronic Data Interchange submission

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

Clearinghouse	Payor ID	Provider Support
Smart Data Solutions	38261	1-855-297-4436

The guide for EDI claims submission is located on our website at **DellChildrensHealthPlan.com.** The guide includes additional information related to the EDI claim process. To initiate the electronic claims submission process or to obtain additional information, please contact Smart Data Solutions at **1-855-297-4436** or **stream.support@sdata.us** for further assistance.

Online claims submission

We offer a free online claim submission tool for all providers at link: **portal.smartdatastream.us/quickclaim/servlet/quickclaim/template/ClearingHouse,Login.vm**
This tool submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration.

Paper claims submission

We accept paper claim submissions through either of the following forms that are applicable to your group:

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

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

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

Submit paper claims to:

Dell Children's Health Plan
PO Box 37502
Oak Park, MI
48237-0502

Itemized bills

An itemized bill is required under the following circumstances:

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

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

Dell Children's Health Plan
PO Box 37502
Oak Park, MI
48237-0502

Claims status

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

- Provider portal **secure.healthx.com/Provider_2022**
- Provider Services at **1-844-781-2343 (TTY 7-1-1)**

Capitation

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

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

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

Provider reimbursement

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

Federal regulations require state Medicaid agencies to revalidate provider enrollment information every 3-5 years. If a provider's re-enrollment is not complete by the required date the provider will not be able to receive payments for Medicaid services. Compliance with the re-enrollment process is solely the responsibility of the provider. Additional information is available through TMHP, the state agency responsible for provider enrollment.

EDI claims submissions (837)

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

Here is the clearinghouse we work with and how to contact them:

Clearinghouse	Payor ID	Provider Support
Smart Data Solutions	38261	1-855-297-4436

Please contact Smart Data Solutions at **855-297-4436** or **stream.support@sdata.us** for further assistance.

Electronic Funds Transfer and Electronic Remittance Advice

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

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

To register for ERA/EFT, please call Zelis to enroll at **1-877-828-8770**.

Primary care provider reimbursement

We reimburse primary care providers according to their contractual arrangement.

Specialist reimbursement

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

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

Overpayments

We are entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us. Overpayments may be identified by our Cost Containment Unit (CCU), a Dell Children's Health Plan vendor or the provider. When an overpayment is identified by the CCU or a Dell Children's Health Plan vendor, the provider will receive written notification. The notification will include a Refund Notification Form specifying the reason for the return, to be completed by the provider and returned along with the refund check. This form can be found on our provider website at **DellChildrensHealthPlan.com**. The submission of the Refund Notification Form allows us to process and reconcile the overpayment in a timely manner. Providers can also proactively notify us of an overpayment. It is not uncommon for a provider to identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Provider-preventable conditions

We are required to use the present-on-admission (POA) indicator information submitted on inpatient hospital claims and encounters to reduce or deny payment for provider-preventable conditions. This includes any hospital-acquired conditions or health care-acquired conditions identified in the Texas Medicaid Provider Procedures Manual. Reductions are required regardless of payment methodology and apply to all hospitals including behavioral health hospitals.

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

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

Claim audits

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

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

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

Coordination of benefits

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

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

We will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases. Review and research encompasses generating multiple letters and phone calls to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor.

Billing members

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

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 95-day filing deadline
- Failure to submit a corrected claim within the 95-day filing resubmission period

- Failure to appeal a claim within the 120-day administrative appeal period
- Failure to appeal a utilization review determination within 30 calendar days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

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

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

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the client acknowledgment statement, specifying he or she will be held responsible for payment of services.
- Understand he or she may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

Private pay agreement

Providers:

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

Sample:

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

Signed

_____

Date

_____

Member acknowledgment statement

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

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

Client acknowledgment statement form

I understand my doctor, _____, or Dell Children's Health Plan has said
Provider name

the services or items I have asked for on _____, are not covered under
Dates of services

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

_____ Date: _____

Member name (print)

_____

Member signature

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

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

_____ Date: _____

Provider name (print)

_____

Provider signature

Cost sharing

Medicaid cost sharing

Medicaid members do not have copays.

CHIP cost sharing

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

- Information about copays and annual reporting caps is based on family income; the CHIP member ID card shows the member's copay amount
- Members must report to Texas CHIP when they or their family reach the annual reporting cap; once the cap is met, the member will be issued a new ID card
- Upon verbal notification from the member or presentation of an ID card showing that the cost sharing limit has been met, no copay is collected from the member for the balance of the year

Cost sharing guidelines require that providers:

- Only bill for valid, unpaid copays and non-covered services received by the member
- Promptly refund member overpayments if an incorrect copay was collected for covered services
- Not collect additional payment once the copay is made
- Verify eligibility and copay amounts by calling provider services at **1-844-781-2343 (TTY 7-1-1)**

Cost sharing exemptions include:

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

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

- Well-baby and well-child care services, as defined by 42 C.F.R. §457.520; preventative services, including immunizations;
- Pregnancy-related services;
- Native Americans or Alaskan Natives;
- CHIP Perinatal members (Perinates (unborn children) and CHIP Perinate Newborns);

- Outpatient office visits for mental health (MH) and substance use disorder (SUD) services and MH/SUD residential treatment services, in accordance with 42 CFR §457.496(d)(2)

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

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

CHIP cost sharing schedule

Copay information is shown in the table below:

CHIP Cost-Sharing (Effective July 1, 2023)	
Enrollment Fees (for 12-month enrollment period):	**Charge**
At or below 151% of FPL*	**$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)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin. $35 for all other drugs***
Facility Co-pay, Inpatient (per admission)	$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.

CHIP Perinatal postpartum billing

Although the mother's eligibility expires after delivery, claims received for postpartum services will be paid. To ensure payment for the postpartum visits, the codes listed below must be used to report postpartum care. Providers will bill postpartum visits as follows:

- Providers must bill CPT Code 59430 one time and use an E/M code 99211-99215 and a diagnosis restriction of postpartum related ICD- 10 Codes Z39.0, Z39.1, and Z39.2 for the additional postpartum visits.

Emergency services

Prior authorization is not required for coverage of emergency services. Any hospital or provider request for authorization of emergency services is granted immediately. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Special billing

When billing a newborn claim, use the newborn's Medicaid ID. If no ID has been assigned yet, call us at **1-844-781-2343 (TTY 7-1-1)** for assistance. Do not submit a claim under the mother's global ID.

Provider payment appeals

Information on the payment appeal process, including acute care claims, is located in the provider complaints and appeals process chapter.

Out-of-network providers

Claims submission

Non-participating providers located in Texas must submit clean claims to us within 95 days of service.

Non-participating providers located outside of Texas must submit clean claims to us within 365 days of the date of service. Refer to the definition of clean claim in the billing and claims administration chapter of this provider manual. To submit claims for services provided to Medicaid members, providers must be enrolled with Texas Medicaid and active on the file with TMHP, the state's contracted administrator.

Prior authorization

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

Reimbursement

Non-participating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For Medicaid we reimburse:

- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less five percent
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate

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

APPENDIX A

Community First Choice

Program provider responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation, which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member that are required to ensure the member's health, safety and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline (1-800-647-7418).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED or competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.

- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC PAS or Habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints, must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

APPENDIX B

Reporting abuse, neglect, or exploitation (ANE)

Medicaid managed care

Report suspected abuse, neglect, and exploitation:

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

Report to the Department of Aging and Disability Services (DADS) 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 DADS;
- Adult day care centers; or
- Licensed adult foster care providers

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

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

- An adult 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 DADS;
    - 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; community
    - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
    - a managed care organization;

    - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

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

dell children's
Health Plan

We go above and Beyond

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