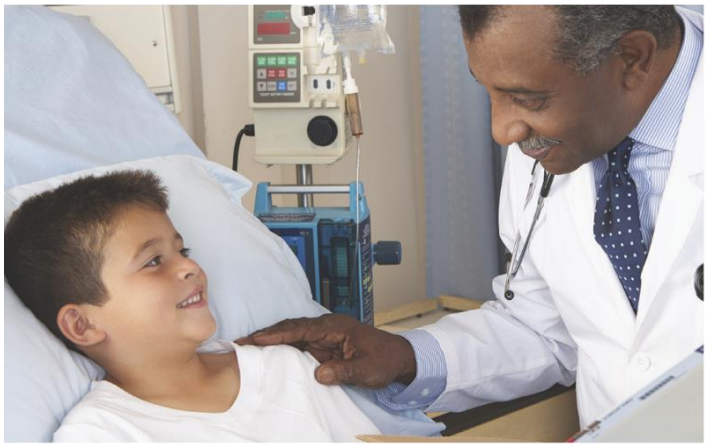
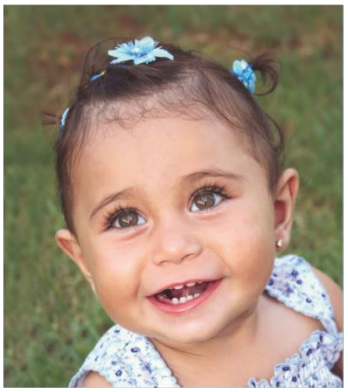
Driscoll Health Plan





Provider Manual

August 2024

HIDALGO SERVICE AREA

STAR - 1 (855) 425-3247

STAR Kids - 1 (844) 508-4674

NUECES SERVICE AREA

STAR / CHIP - 1 (877) 324-3627

STAR Kids - 1 (844) 508-4672

www.driscollhealthplan.com

PR – 001

CHIP

TEXAS STAR
Your Health Plan ★ Your Choice

TEXAS STAR Kids
Your Health Plan ★ Your Choice

An affiliate of Driscoll Health System

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Document History Log

STATUS	REVISION DATE	DESCRIPTION
Updates / Revision	March 24, 2020	Pg. 77 – Note for Driscoll Fee Schedule Pg. 97 – Verifying Member Medicaid Eligibility (State Language) Pg. 103 – STAR/STAR Kids Medicaid Covered Services (Update Specialty Physician Services – No auth. Required) Pg. 104 – Updated Behavioral Health Covered Services Pg. 192 – Billing for CHIP Perinate Services (Claims for Professional Services) Pg. 224 – STAR, CHIP & STAR Kids QRT Pg. 229 CHIP Perinate QRT Pg. 232 – STAR Kids LTSS QRT
Updates / Revision	May 12, 2020	Pg. 135 – EVV Section completely redone. Pg. 142 - Added SIU Surveillance Plan
Updates / Revision	September 30, 2020	Pg. 104 – Behavioral Health Service Chart Updated Pg. 226 – Star, Chip and STAR Kids QRT Pg. 232 – Chip Perinate QRT Pg. 235 – STAR Kids LTSS QRT Pg. 237 – Star Value Added Services Pg. 239 – Chip Value Added Services Pg. 241 – Chip Perinate Value Added Services Pg. 242 – STAR Kids Value Added Services
Updates / Revision	December 28, 2020	Pg. 44 – Removing Code CPT D1208 Pg. 87 – Updated UB Example Pg. 124 – Removing Code CPT D1208 Pg. 143 – Added new language at the bottom of the SIU Pg. 226 – Updated QRT – STAR, CHIP & STAR Kids
Updates / Revision	April 19, 2021	Updated Driscoll Health Plans Address – 4525 Ayers Street ~ Corpus Christi, Texas 78415-1401 Pg. 52 – Utilization Management – Reorganize either section Pg. 103 – Update Behavioral Health & Chemical Dependency Benefits at a Glance – Update either Chart Pg. 81 – Coordination of Benefits – Language Updated Pg. 83 – Administrative Claim Appeals – Language Updated Pg. 126 – Appeals, Complaints, Peer-to-Peer Conversations & State Fair Hearings – Language Updated Appendix – Updated QRTs
Updates / Revision	August 31, 2021	Pg. 37-40 – Compliance – Updated Language Pg. 88 – Quality Management – Updated Language Appendix – Sample ID Cards VAS – Effective 9/1/2021-8/31/2022
Updates / Revision	December 30, 2021	Pg. 17 – DHP Subcontractors: Updated verbiage Pg. 18 – Revised Anti-Discrimination laws to reflect UMCC v.2.34 Pg. 22 – Removed STAR Kids covered benefits statement from Provider Enrollment section Pg. 30 – Revised Committee Names Pg. 32 – Updated language for accessibility standards and appointment availability table Pg. 41 – Clarified information to be to be provided when reporting a possible HIPAA breach Pg. 47 – Removed reference to Mental Health and Mental Retardation

STATUS	REVISION DATE	DESCRIPTION
		Pg. 51 – Revised Committee name; Highlighted statement "DHP does not require authorization for court-ordered services." Pg. 53 – Add Inpatient Fax number Pg. 89 – Changes Section Title to remove HEDIS® and replace with Performance Pg. 90-91 – Revised verbiage for shredding PHI received in error. Added verbiage for attestation of PHI destruction Pg. 91-91 – Updated Committee names Pg. 101 – Inserted STAR Kids covered benefits statement from Pg. 22 Pg. 184 – Provider Disputes – Performance Excellence contact information updated.
Updates / Revision	March 1, 2022	Pg. (s). 14, 17, 102, 103, 126 - Changed NEMT provider to SafeRide Health.
Updates / Revision	May 1, 2022	Expedited changed to Emergency in appropriate sections throughout the manual. Font, formatting and grammatical changed throughout the manual. Pg. 60 – Revised *Requests to extend a current course of treatment* and *Reductions or terminations of a previously approved course of treatment* – clarification of process. Pg. 62 –. Added *Eligibility Issues and Late Notification* – process for late notification and retro-enrollment for authorizations. Pg. 88 – Updated membership of EQC. Pg. 119 – Removed language requiring an oral appeal to be submitted in writing; added email address for appeal submission. Pg. 120 - Removed language requiring an oral appeal to be submitted in writing; added statement member option to choose External Medical Review and State Fair Hearing or State Fair Hearing only. Pg. 120 - Added statement member option to choose External Medical Review and State Fair Hearing or State Fair Hearing only. Pg. 122 – 123: Changed title; added *External Medical Review* required language. Pg. 128 – Added 5.e. member right to external medical review and state fair hearing; modified 5.e. revised to member right to State fair hearing without external medical review. Pg. 133-134: – Added *MDCP/DBMD Escalation Help Line* and required language. Pg. 197 – Added *Claims for Delivery and Postpartum Services* clarification for billing
Updates / Revision	September 1, 2022	Pg. 77 – Revised ages for sprots physical for STAR, STAR Kids & CHIP Pg. 100 - Added *Children and Pregnant Women (CPW) Services* – description and contact information under covered services. Pg. 105 - Removed Children and Pregnant Women (CPW) Services language. Pg. 109 - Removed Children and Pregnant Women (CPW) Services language.
Updates / Revision	September 15, 2022	TOC – Updated Pg. 13 – Revised BH hotline and Nurse Advise Line Phone Numbers Pg. 17 & 53 – Added Carenet Solutions as vendor Pg. 26 – Added American Sign Language Pg. 32 – Revised reasons for PCP to request removal of a member from a panel Pg. 47 – Update BH Hotline Numbers Pg. 72 – Change vender to Change Healthcare Pg. 75 – Update phone and fax numbers Pg. 77 – Revised ages for Sports Physical Pg. 92 – Revised Credentialing to clarify role of CVO, revised site visit requirements Pg. 126 & 193 – Add need to complete internal appeal process related to claims and payment issue prior to escalation to provider dispute. Pg. 127-128 & 193-194 – Added Provider Dispute for Competence or Conduct Pg. 135-144 – Replaced EVV section with revised language from UMCM. Appendix – Updated Member ID cards, VAS for STAR, CHIP and STAR Kids

STATUS	REVISION DATE	DESCRIPTION
Updates / Revision	June 30, 2023	TOC – Updated Pg. 18 – Added Avail Solutions as vendor for behavioral health hotline. Removed behavioral health hotline from Carenet Solutions Pg. 71 – Added Prescription Drug Monitoring Program section Pg. 76 – Revised. Section Filing an Appeal for Non-Payment of a Claim to clarify process and update contact numbers. Pg. 123 – Revised External Medical Review section with language from UMCM Pg. 194 – Updated address for Texas Department of Insurance
Updates / Revision	July 2, 2023	TOC – Updated Pg. 139 – Updated TDI address P.O. Box for complaints
Updates / Revision	December 1, 2023	TOC – Updated Pg. 26 – Added verbiage for off-shore work Section VI Utilization Management – a few updates throughout the section Updated Appendix VAS tables
Updates / Revisions	July 17, 2024	TOC – Updated Pg. 12 – Updated Auditing of Nontraditional LTSS Providers and Vendors verbiage Pg. 14 – Consolidated Member and Provider Services contact information, added MDLive and UHC Dental Pgs. 16-17 – Updated Background and other sections under Introduction Pg. 18 – Updated DHP Subcontractors Pg. 20 – Updated Role of Health Home verbiage Pgs. 23-25 – Updated Vetting of LTSS Providers and Vendors section verbiage Pg. 29 – Updated PCP and Continuity of Care, 1st bullet Pg. 30 – Updated Members Right to Designate an OB/GYN verbiage Pg. 33 – Updated Primary Care Provider (PCP) Changes verbiage Pg. 34 – Updated Appointment Standards table Pg. 36 – Updated Members Right to Self-Referral verbiage Pg. 37 – Updated Marketing Guidelines Affecting Providers table Pg. 37 – Updated bullets under Credentialing and Responsibilities of Mid-Level Practitioner Pg. 38 – Updated DHP and HHSC Requests for Medical Records verbiage Pg. 40 – Updated Cultural Sensitivity verbiage Pg. 42 – Updated Privacy and Security/PHI verbiage Pg. 43 – Updated HIPAA Incident Reporting verbiage; updated Fraud, Waste and Abuse contact information Pg. 44 – Added Record Requests from DHP SIU section/verbiage Pgs. 48-54 – Updated verbiage in various sections of the Behavioral Health Services section Pg. 55-69 – Updated verbiage in various sections of the Utilization Management section Pgs. 71-72 – Updated Pharmacy section verbiage Pg. 74 – Updated Navitus Health Solutions address and phone number Pg. 95 – Updated Initial Credentialing Information verbiage Pg. 121 – Updated Peer-to-Peer Conversations verbiage Pg. 190 – Updated Peer-to-Peer Conversations verbiage Pg. 130 – Updated Filing a Complaint with HHSC table Pgs. 195-196 – Updated Complaints in writing may be forwarded as follows: information

SECTION I

Quick Reference Phone List

Driscoll Health Plan Quick Reference Phone List

Resource	Contact Information
Behavioral Health Hotline CHIP - Nueces (24 hr.)	1-833-532-0218
Behavioral Health Hotline STAR - Hidalgo (24 hr.)	1-833-532-0220
Behavioral Health Hotline STAR - Nueces (24 hr.)	1-833-532-0216
Behavioral Health Hotline STAR Kids - Hidalgo (24 hr.)	1-833-532-0219
Behavioral Health Hotline STAR Kids - Nueces (24 hr.)	1-833-532-0209
CHIP/STAR Case & Disease Management	1-877-222-2759 **| Fax**: 1-361-653-0445
CHIP/STAR Health Services Department	1-877-455-1053 **| Fax**: 1-866-741-5650
DHP Waste Abuse Fraud Hotline	1-844-808-3170
Member Services (CHIP, STAR, STAR Kids)	1-877-324-7543
MDLive	1-800-400-6354
Nurse Advice Line STAR Kids - Hidalgo (24 hrs.)	1-844-714-7887
Nurse Advice Line STAR Kids - Nueces (24 hrs.)	1-844-308-8701
Nurse Advice Line STAR - Nueces (24 hr.)	1-833-532-0221
Nurse Advice Line STAR - Hidalgo (24 hr.)	1-833-532-0231
Nurse Advice Line CHIP - Nueces (24 hr.)	1-833-532-0223
Pacific Interpreter	1-866-421-3463
Provider Services (STAR Kids - Hidalgo SA)	1-877-324-3627
STAR Kids Service Coordination Department (Hidalgo SA)	1-844-508-4675
STAR Kids Service Coordination Department (Nueces SA)	1-844-508-4673
Vision Member Services (CHIP)	1-888-268-2334
Vision Member Services (STAR - Hidalgo SA)	1-877-615-7729
Vision Member Services (STAR - Nueces SA)	1-866-838-7614
Vision Member Services (STAR Kids - Hidalgo SA)	1-844-725-6410
Vision Member Services (STAR Kids - Nueces SA)	1-844-305-8300
Vision Provider Services (Envolve Vision of Texas)	1-800-465-6972

Other Organizations Telephone Numbers

Resource	Contact Information
Child Abuse	1-800-252-5400
Child Protective Services Issues	1-877-787-8999
Childhood Lead Poisoning/DSHS	512-458-7151
CHIP application and enrollment assistance	1-800-647-6558
Comprehensive Care Program/TMHP	1-800-925-9126
DentaQuest – CHIP	1-800-508-6775
DentaQuest – STAR	1-800-516-0165
DentaQuest – STAR Kids	1-800-516-0165
Early Childhood Intervention (ECI) Care Line	1-800-628-5115
Eligibility Line (STAR) - Automated Inquiry System (AIS)	1-800-925-9126
MCNA - CHIP or STAR	1-855-691-6262
MCNA - STAR Kids	1-800-494-6262
Medical Transportation Services (STAR/STAR Kids)	1-877-633-8747
Pharmacy – Navitus Questions – Hidalgo SA- STAR	1-855-425-3247
Pharmacy – Navitus Questions – Hidalgo SA-STAR Kids	1-855-425-3247
Pharmacy – Navitus Questions – Nueces SA-STAR	1-877-220-6376
Pharmacy – Navitus Questions – Nueces SA-STAR Kids	1-877-220-6376
Pharmacy – Navitus Questions- CHIP	1-877-451-5598
Pharmacy (Vendor Drug Program) Questions	1-800-435-4165
SafeRide Health	1-833-694-5881
Texas Health Steps – Corpus Christi	361-888-7837
Texas Vaccines for Children Program	1-800-252-9152
TMHP (To enroll as a Texas Health Steps Provider)	1-800-925-9126 *(Option 2)*
UHC Dental	1-877-901-7321
Women, Infant, Children (WIC)	1-800-942-3678

SECTION II
Introduction

Background of Driscoll Health Plan

Driscoll Health Plan (DHP) is a vital part of the Driscoll Health System and proudly stands alongside Driscoll Children's Hospital, an institution that has been the cornerstone of care for South Texas children and their families for more than 70 years.

DHP is a non-profit, community-based health insurance organization devoted to improving the lives of South Texas families. We cover a 14-county area surrounding Nueces County and a 10-county area in the Rio Grande Valley. We serve children, young adults, and expecting mothers through our STAR, STAR Kids, and CHIP programs. DHP's extensive provider network consists of primary care physicians (PCPs), specialty, and LTSS providers that are dedicated to the care and treatment of all members.

Our philosophy and the proud heritage of the Driscoll Health System began under the guidance and vision of the hospital's benefactor, Clara Driscoll, and that of Dr. McIver Furman in the late 1940's. In 1998, the Driscoll Foundation developed and funded what would become a beacon of health and hope for our community. That same year, the Texas Department of Insurance (TDI) licensed Driscoll Health Plan as a Health Maintenance Organization (HMO). That philosophy has permitted Driscoll to grow into the expansive and capable health care organization that it is today.

DHP Mission and Vision Statement

Mission: "Devoted to expert care, education, outreach and advocacy."
Vision: "Until all children are well."

Get Ready For Baby

In 2006, the Cadena De Madres (Network of Mothers) program was established through a Title V grant with the aim of reducing premature births by equipping women with education and resources for a healthy pregnancy. In 2013, DHP took over the program, providing ongoing community support. In 2019, the program underwent enhancements and rebranding, now known as Get Ready For Baby. It offers comprehensive support to expectant mothers across our service areas, empowering them with knowledge on self-care during and after pregnancy, fetal development, baby care, and child safety. Our offerings include educational baby shower events, home visits, and parenting classes, all available in both English and Spanish, and through in-person and virtual formats.

Integrated Oral Healthcare

Fluoride varnish performed by PCPs began as an exclusive DHP pilot to reduce severe caries in children and is now integrated into the THSteps program. To measure program success, we track oral exams and varnish applications that PCPs conduct as well as reductions in operating room (OR) services. In the first five years, we documented $8.5 million savings in OR and anesthesia costs alone. We offer an alternative payment model (APM) to incentivize pediatricians to work with dental Providers. At Driscoll Health Plan, we have appointed an Associate Dental Director who collaborates with our Dental Maintenance, Quality, and Population Health teams to develop interventions to improve oral health and hygiene during THSteps visits, ensuring smooth integrated care and referrals for high-risk members.

Products

Driscoll Health Plan functions as an administrator for:

- CHIP
- STAR
- STAR Kids

Medicaid managed care programs through a contract with the Texas Health and Human Services Commission (HHSC).

Children's Health Insurance Program (CHIP)
DHP has been a CHIP contractor since the CHIP program began in 2000. This healthcare program is designed for newborns and children up to 18 years of age who do not qualify for Medicaid. The CHIP program may require members to pay enrollment fees and copays. Benefits include regular checkups, immunizations, prescription drugs, lab tests, x-rays, hospital services (inpatient, outpatient and emergency room), and more. CHIP families must renew their coverage yearly.

State of Access Reform (STAR) Medicaid Managed Care
DHP has been a STAR contractor since 2006. STAR is a Medicaid program offering healthcare coverage for newborns, children, pregnant women and adults of low-income families at no cost. Benefits include regular checkups, immunizations, prescription drugs, lab tests, x-rays, hospital services (inpatient, outpatient and emergency room), and more. STAR members must renew their coverage yearly.

State of Access Reform (STAR) STAR Kids Medicaid Managed Care
DHP has been a STAR Kids contractor since 2016. STAR Kids is a Medicaid program who serves children 20 and younger who either receive Supplemental Security Income (SSI) Medicaid or are enrolled in the Medically Dependent Children Program (MDCP). Children and youth who receive services through other 1915 (c) waiver programs will receive their basic health services (acute care) through STAR Kids.

The STAR Kids program provides a full range of Acute Care Medical Health Services and Long-Term Care, Long Term and Support Services (LTSS) to youth and children who receive disability-related Medicaid.

STAR Kids (State of Texas Access Reform Kids) is the Medicaid-managed healthcare program for low-income families with children who have disabilities. It provides 12 months of health coverage for qualifying children and adults up to 20 years old. To participate in the STAR Kids program, members must be covered by Medicaid and meet at least one of the following conditions:

- Get Supplemental Security Income (SSI).
- Get Medicaid and Medicare.
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility.
- Get services through the Medically Dependent Children Program (MDCP) waiver.
- Get services through the Youth Empowerment Services (YES) waiver.
- Get services through any of the following intellectual and developmental disability (IDD) waiver programs:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities (DBMD)
    - Home and Community-based Services (HCS)
    - Texas Home Living (TxHmL)

DHP Philosophy of Business

DHP has established a cohesive collaboration with its physician network; one that strives to be inclusive and educative rather than punitive. This approach has gained DHP the respect and cooperation of the physician community. Physicians are very involved, through the Chief Medical Officer, Medical Director and/or Associate Medical Directors (collectively referred to in this manual as "Medical Director"), in developing clinical guidelines and in creating programs to benefit the Coastal Bend and South Texas area. These strong and mutually beneficial relationships have come together to ensure excellence in the delivery of health care services to DHP Members, and Healthy Smiles, DHP and community physicians have collaborated on programs that benefit not only the enrolled Members of the health plan, but the entire community.

DHP Program Objectives

The DHP program objectives focus on:

- comprehensive well-child care, including childhood immunizations
- service coordination opportunities to coordinate care
- Asthma and diabetes disease management programs to collaboratively improve control of these chronic conditions with affected Members.
- early and continuous prenatal care for pregnant Members geared to improve birth outcomes
- effective behavioral health care services, including medication management outreach
- care coordination for children with special health care needs
- healthy lifestyle promotion to prevent and treat obesity
- effective acute and LTSS services for youth and children who qualify for disability-related Medicaid services

DHP Contracted Group Providers & Non-contracted Health Care Providers

All health care providers not contracted with DHP but utilized by a contracted Group Provider in providing covered services to Members, including but not limited to, mid-level practitioners, nurses, laboratory technicians, x-ray technicians, medical assistants, and other ancillary care providers, must comply with all applicable training, licensing and certification requirements, and must practice only within the scope of their licenses and certifications as permitted by law. All such group providers shall be subject to the terms and conditions of the DHP Group Provider Agreement. Group Providers shall:

a. maintain records with respect to such health professionals that are sufficient to document such compliance and provide such proof to DHP upon request;
b. appropriately supervise such health professionals in the performance of their duties; and
c. require all such health professionals to accurately identify themselves to Members. Provider shall ensure that such health professionals obtain and maintain whatever type and amount of professional liability insurance as may be required by DHP for that class of provider.

DHP Subcontractors

DHP administers its own programs, manages all quality management processes, ensures compliance with the state contract, and oversees the development of its comprehensive network of providers and facilities. DHP contracts with subcontractor organizations to provide services. Subcontractors include:

- **Avail Solutions, Inc**., who provides the Behavioral Health 24-hour hotline for Members.
- **Carenet Health, Inc.,** who provides the 24-hour Nurse Advice Line for Members.
- **Envolve Vision of Texas,** who provides the vision benefit for DHP Members.
- **Navitus Health Solutions, LLC,** a Pharmacy Benefit Manager (PBM) who provides prescription drugs to DHP Members.
- **SafeRide Health, Inc.**, who provides Nonemergency Medical Transportation (NEMT), services.

DHP & Contracted Providers Discrimination Policy

Non-Discrimination

Driscoll Health Plan (DHP) complies with Section 1557 of the Patient Protection and Affordable Care Act (42 USC 18116) and its implementing regulations, which provide that no individual will be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited. The Office of Civil Rights (OCR) is responsible for enforcing regulations issued under Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex (including sexual orientation and gender identity), age, or disability in covered health programs or activities.

DHP and all DHP contracted providers must comply with all State and Federal Anti-discrimination laws including but not limited to:

a. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d et seq.);
b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
c. Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.);
d. Age Discrimination Act of 1975 (42 42 U.S.C. §§ 6101-6107);
e. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688 regarding education programs and activities);
f. Food and Nutrition Act of 2008 (7 U.S.C. §§ 2011 et. Seq.); and
g. The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent of this agreement.

If you believe you have been discriminated against on one of the bases protected by Section 1557, you may file a complaint with OCR in writing within 180 days by any of the following methods:

1) Mail to: U.S. Department of Health and Human Services, Centralized Case Management Operations, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201
2) E-mail to: OCRComplaints@hhs.gov
3) OCR Complaint Portal at https://ocrportal.hhs.gov/ocr/.

Role of Primary Care Provider

The Primary Care Provider ("PCP") is the cornerstone for Driscoll Health Plan. The PCP serves as the medical home for the DHP Member. The medical home concept should help in establishing a relationship between the patient and provider, and ultimately improve health outcomes. The PCP is responsible for the provision of all primary care services for the DHP CHIP, STAR, and STAR Kids Members. In additions, the PCP is responsible for facilitating referrals and authorization requests for specialty services to DHP network providers, as needed. The PCP may choose to establish a DHP Health Home by working with DHP to provide a more comprehensive array of health services and supports as described in the following section. *For more information on the responsibilities of the PCP, see "III – Provider Responsibilities" in this manual.*

***Note**: STAR Kids Dual eligible members are not required to have a PCP.*

Role of the Specialty Care Provider

The Specialty Care Physician collaborates with the Primary Care Provider (PCP) to deliver specialty care to Members. A key component of the Specialty Care Physician responsibility is to maintain ongoing communication with the DHP Member's Primary Care Provider (PCP). Specialty Care Providers are responsible to ensure necessary referrals/ authorizations have been obtained prior to provision of services. DHP encourages each of its members to have a PCP; there will be circumstances where specialty physicians will perform in the role of a PCP. This will occur only when the complexity of ongoing medical care for the member goes beyond those capabilities typically possessed by the PCP. *For more information on the responsibilities of the Specialty Care Physician, see "III – Provider Responsibilities" in this manual.*

In STAR Kids, each Member (except the Medicare/Medicaid duals) has a Primary Care Physician (PCP) who typically provides basic care and helps guide the Member through the continuum of health care services by coordinating medically necessary specialty services. The role of the PCP is to ensure access to high quality, affordable health care services as needed.

Providing quality health care services at a reasonable cost requires thinking in different terms for many chronic medical conditions: disease management. At the core of disease management is a system of care for particular conditions such as asthma, diabetes, obesity, or high blood pressure that also requires the expertise of specialty physicians. This requires more teamwork between PCPs and Specialists. Sometimes there will be referrals to Specialists for very specific problems requiring just a few visits to the Specialists. There will be other times when the referral may be for longer times and involve a myriad of diagnostic tests, medical procedures, or recommendations for durable medical equipment or additional

therapies. Thus, there will be unique cases where it works best for the member that the specialist functions as a PCP. At its most comprehensive, and theoretically most effective, disease management takes in all of the providers and facilities that would ordinarily deal with a patient and integrate health care delivery to best suit the needs of the member.

Role of Health Home

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include operational characteristics of accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The Institute for Health Care Improvement (IHI) put forth what is referred to as the triple aim: 1) improved access to health care, 2) increased clinical quality and population health, and 3) decreased utilization leading to decreased cost of health care.

The defining characteristics of a Health Home are:

- Comprehensive medical care
- Enhanced access to the care delivery team
- Coordinated care
- Team-based approach
- Diseases registry
- Patient engagement

A Health Home is also a part of the care management enterprise. Driscoll Health Plan has created a Health Home Model that incorporates these characteristics.

DHP encourages all PCPs to create a Health Home within their practice, thus providing access to a Health Home for any Member that DHP determines would most benefit from a Health Home or for any Member who requests a Health Home.

A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access to health care, support coordination between Providers, and provide for high-quality health care.

The DHP Health Home model begins with a person-centered approach to holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or medical health condition. The DHP Health Home Model addresses the IHI Triple Aim.

The DHP Model Health Home services must include:

1. Patient-centered/family-centered health care;
2. Evidence-based models with minimum standards of high quality health care;
3. Patient and family support (including legally authorized representatives);
4. Patient self-management education; and
5. Provider education.

DHP Health Home Services may also include:

1. A mechanism to incentivize providers for provision of timely and quality care;
2. Implementation of interventions as well as quality improvement initiatives that address maintaining and/or improving the continuum of care;
3. Mechanisms to modify or change interventions that are not proven effective;
4. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;
5. Comprehensive care coordination and health promotion;
6. Palliative care options in the event of a life-limiting diagnosis;

7. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
8. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;
9. Referral to community and social support services, if relevant; and
10. Use of health information technology to link services, as feasible and appropriate

DHP has developed a provider incentive program for designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

DHP will:

1. Track and monitor all Health Home Services participants for clinical, utilization, and cost measures;
2. Implement a system for Providers to request specific Health Home designations;
3. Inform Providers about differences between recommended prevention and treatment and actual care received by Members enrolled in a Health Home Services program as well as Members' adherence to a service plan; and
4. Provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home Services program.

For more information about Driscoll's incentive program to be a Health Home, please contact Provider Relations.

Role of the Long-Term Services and Support (LTSS) Provider

The Long-Term Services and Supports (LTSS) provider delivers medically necessary and functional necessary services to the STAR Kids (SK) Medically Dependent Children's Program (MDCP) Members. Services include Personal Care Services, Private Duty Nursing, Adaptive Aides, Minor Home Modifications, CFC benefits (Habilitation, Emergency Response Service, and Support management), Respite, Employment services (Supported Employment, Employment Assistance), Financial Management Services, Flexible Family Support Services, and Transition Assistance Services. The LTSS provider obtains prior authorization and coordinates delivery of services in collaboration with the Member, Member's PCP, and DHP's Service Coordinator.

The LTSS provider works in partnership with care planning and service coordination services to allow DHP STAR Kids members to have an active role in their health care and to remain in the community. Long-term services and supports providers encompass the broad range of non- medical and personal care assistance that these members may need, for several weeks, months, or years, when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. LTSS services require a prior authorization. *For more information on the responsibilities of the LTSS Provider, see "III – Provider Responsibilities" in this manual.*

Role of the MCO Services Service Coordinators

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity. The scope of services are offered to assist a Member in attaining, maintaining, or regaining functional capacity. Service Coordination is provided by a Service Coordinator I - Registered Nurse (SCI-RN), Service Coordinator II- Social Worker (SCII -SW) or Service Coordinator III- Licensed Vocational Nurse or unlicensed staff (SCIII- LVN or SCIII). The Service Coordinators will collaborate with interdisciplinary teams that could include, but not limited to, other members of the Service Coordination Team, providers, specialist, community resources, and others to ensure members needs are being met.

Role of Transition Coordinator (Specialist)

Transition Specialists are employees of the DHP and wholly dedicated to counseling and educating Members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the

Member in the transition process. See STAR Kids Section for additional information on the Role of the Transition Specialist.

Role of CHIP Perinate Provider

Expectant mothers enrolled in CHIP Perinate will not have an assigned Primary Care Provider (PCP) on their ID card. Since benefits are limited to prenatal care only, there will be a pregnancy care provider listed which may be a Family Practice physician, OB/GYN physician, Internal Medicine physician, Advanced Nurse Practitioner, Certified Nurse Midwife or Clinic. The CHIP Perinate Provider will function as the main provider for the CHIP Perinate member.

Role of Pharmacy

DHP is sub-contracted with a Pharmacy Benefits Manager (PBM) to provide prescription drugs to our members. The PBM for DHP is Navitus. This PBM holds the contracts with the individual pharmacies. The Pharmacy is contracted to provide all prescription drugs that are included on the DHP formulary. For any questions regarding formulary, or anything regarding prescription drug coverage, contact us at the Provider Services number at the bottom of this page. *For additional information regarding Pharmacy benefits, see Section VII of this manual.*

Role of 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 *(e.g. Primary Care Providers (PCPs), Specialty Care Physicians, and OB/GYNs)*

Members are limited to the use of a provider in network and contracted with Driscoll Health Plan. Exceptions can be made when continuity of care would be disrupted if the Member did not continue with an out-of-network provider. All out-of-network referrals require prior authorization and must be approved by the Medical Director. *For more information on referrals to out-of-network providers, see "III – Provider Responsibilities" in this manual.*

Provider Enrollment in DHP Medicaid Managed Care Programs

Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by Driscoll Health Plan. To be reimbursed for services rendered to DHP Medicaid Managed Care clients, Providers must be enrolled in Texas Medicaid and then must enroll with DHP to be eligible for reimbursement for covered services rendered. All Providers joining existing groups should enroll in Texas Medicaid and then submit a request to DHP to be credentialed and added to the group upon approval by the DHP credentialing committee.

***Note**: Facility enrollment does not require enrollment of performing providers, examples are FQHCs, RHCs and CORFs however, the facility must be enrolled in Texas Medicaid before they can be contracted and credentialed by Driscoll Health Plan.*

Vetting of LTSS Providers and Vendors providing STAR Kids Covered Benefits (Including Non-Traditional)

LTSS Provider

A traditional medical services provider with a National Provider Identifier (NPI) number that supplies certain LTSS and is signed-up with and in good standing with the Texas Health and Human Services Commission (HHSC) and thereby authorized to provide services to Texas Medicaid recipients. Providers in this category are credentialed in accordance with DHP's URAC-compliant credentialing policies and procedures and are not covered under this policy. Examples of LTSS Providers are:

- Durable Medical Equipment (DME) companies supplying Adaptive Aids.
- Home Health Agencies (HHA) providing Personal Care Services (PCS), Private Duty Nursing (PDN), Personal Attendant Services (PAS), or in-home Respite services.
- Home and Community Support Service Agencies (HCSSA) providing any or all of these services: Flexible Family Support Services (FFSS), Employment Assistance (EA), Supported Employment (SE), Minor Home Modification (MHM) services, or Transition Assistance Services (TAS).

LTSS Vendor

A provider of LTSS that does not meet the definition of LTSS Provider that is: (a) not a traditional medical provider, (b) does not have an NPI but invoices or bills DHP under an Atypical Provider Identifier (API) number, and (c) performs largely non-medical wrap-around support services or personal attendant services under the Consumer-directed Services (CDS) option such as:

- MHM performed by general construction contractors or home remodeling services companies.
- Vehicle Modification or Vehicle Lift services (an Adaptive Aid LTSS benefit available to some STAR Kids member families) performed by specialty automobile service vendors.
- Employment services (EA or SE) performed by employment services agencies.
- Financial Management Services (FMS) rendered by a Financial Management Services Agency (FMSA).
- Transitional Assistance Services (TAS) providers.

The process for the vetting of nontraditional LTSS Vendors contracted with DHP encompasses a comprehensive initial and ongoing annual review and continual oversight of all nontraditional LTSS Providers and LTSS Vendors prior to and while performing services for DHP members. This process includes the initial assessment and verification of background information and legitimacy to provide or perform services within an outlined scope of work. It also includes a re-assessment any time there are quality issues identified in the care of a member or concerning the services performed for a member. Member safety and well-being is the upmost and highest priority for DHP.

Prior to renewal of contract for these specific types of providers, a list of the provider contracts to be renewed is sent to the Quality Management (QM) Department to review for any quality issues that may have occurred during the past year. Quality issues from Quality Management (QM) Department are reviewed and presented to STAR Kids Executive Team for final continuance determination prior to renewal.

Vetting of Nontraditional LTSS Vendors

Before contracting with nontraditional LTSS Vendors, DHP will ensure that the vendor's applicable employees or agents:

- have not been convicted of a crime listed in Texas Health and Safety Code §250.006 (see **http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.250.htm#250.006** for clarification);
- are not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by Department of Aging and Disability Services (DADS) by searching or ensuring a search of such registries is conducted, before hire and annually thereafter (see **https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp**);

- are not listed on the following registries as excluded from participation in any federal or state health care program: by searching or ensuring a search of such registries is conducted yearly.
  - HHS-OIG Exclusion (see http//exclusions.oig.hhs.gov/)
  - HHSC-OIG Exclusion Search; (see **http://oig.hhsc.state.tx.us/oigportal/EXCLUSIONS.aspx**);
  - Federal Sysytem for Award Management (SAM) Exclusions (see https://sam.gov/content/exclusions)
  - Office of Foreign Assets Control (OFAC) (https://sanctionssearch.ofac.treas.gov/)
  - HHS-OIG Corporate Integrity Agreement (CIA) (https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp)
  - National Plan & Provider Enumeration System (NPPES) (https://npiregistry.cms.hhs.gov/search)
  - HHSC Long-term Care Provider Search (including Inspection results and Enforcement Actions) (https://apps.hhs.texas.gov/LTCSearch/namesearch.cfm)
  - For Adult Day Care (Day Activity & Health Services) DAHS Facility Directory (https://www.hhs.texas.gov/providers/long-term-care-providers/day-activity-health-services-dahs)
- as appropriate to the vendor type, DHP will obtain verification that vendors are properly licensed in Texas to perform the contemplated services, carry appropriate amounts of liability or other insurances, and/or are doing business in good-standing with governmental agencies of competent jurisdiction;
- are knowledgeable of acts that constitute Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS) of a Member (this is to be acknowledged by the provider at initial provider in-service and renewed yearly);
- are instructed on and understand how to report suspected Abuse, Neglect, or Exploitation; (number to these hotlines as well as website reporting information will be given to provider at initial in-service and renewed yearly);
- adhere to applicable state laws if the vendor will be providing transportation to members or their families;
- are not a spouse of, the legally responsible person for, or the employment supervisor of the Member who receives the service, except as allowed in the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver (indication of acknowledgement and vow of adherence to this policy will be indicated by signature of provider at initial in-service and renewed yearly); and
- Are instructed about applicable DHP policies and procedures related to authorization of services, scope of work permitted, limitations, if any, of services that may be provided, and DHP policies related to submitting claims for payment.

Revetting of LTSS Vendors

Nontraditional LTSS Vendors will be revetted at least 90 days' prior the termination date of the vendor's contract for services with DHP. The Director of Special Investigations, and the DHP Quality Management Department shall work cooperatively as needed to review all known information regarding the:

- LTSS Vendor's services and service reliability
- audit results
- history of member complaints
- compliance with or achievement of applicable quality metrics
- appointment and after-hours availability, if applicable
- utilization rates, if applicable
- member satisfaction results

Results of the above determinations shall be reviewed with the Chief Medical Officer, the STAR Kids Medical Director, the STAR Kids Director, the Director of Provider Relations, and Director of Credentialing/Provider Data Management. Quality issues identified during the above processes will be reviewed by the Director of Quality Management. These individuals will seek input from other DHP departments or employees as deemed appropriate. The review team will authorize or deny the solicitation for renewal of the Non-Traditional LTSS Vendor's contract.

Termination of Nontraditional LTSS Vendors

Based on the sole discretion of DHP, nontraditional LTSS vendors' contracts may be terminated if cases where the vendor fails to perform in accordance with its DHP contract or performs in such a manner that is deemed unsafe for

members or is deemed a risk to DHP. Terminated nontraditional LTSS vendors will have no right to appeal their termination. In the event of termination:

- The vendor will be issued written notice of the cause of termination and may, at DHP's sole discretion, be afforded up to a 60-day cure period.
- Members who have been receiving through the terminated provider will be contacted by the Service Coordinator to select an alternate vendor.

Auditing of Nontraditional LTSS Providers and Vendors

The Director of Special Investigations, with the assistance of the Credentialing Department as necessary, conducts all audits, both initially and on a yearly basis to ensure that files are complete, accurate, and free of conflicting information and include all elements needed to be in accordance with applicable state rules and regulations and DHP policies. Audits will be conducted using a quality checklist. Files are also reviewed to ensure that any complaints are documented in the file. These audits include monitoring of turnaround times for renewal and compliance with a timely manner.

In addition, the Director of Special Investigations, or designee, will conduct audits of nontraditional LTSS Vendors and HCSSA entities as necessary, but at least annually, to review their compliance with applicable processes related to the provision and delivery of LTSS and/or CDS options to STAR Kids members and families. These processes may include, but may not be limited to, compliance with:

- Vetting activities described in the "Procedure" section below and delegated to and performed by FMSA or HCSSA entities to ensure the engagement of appropriate and legitimate in-home and at-home providers and vendors of LTSS.
- Obtaining required competitive bids for certain LTSS.

Documenting the receipt of proper inspections for certain LTSS that ensure that modifications or equipment installations are performed safely and in accordance with applicable state or local building codes.

SECTION III
Provider Responsibilities

What is a Health Care Provider?

Health care providers include primary care providers (PCPs), specialty care physicians, behavioral health providers, ancillary providers, long-term services and support providers and other persons involved in the direct care for a member at in and out-patient facilities.

All work performed and all information maintained or stored under your Driscoll Health Plan Agreement, must be performed, stored, and maintained exclusively within the United States.

The Role and Responsibilities of the PCP

Each DHP CHIP, STAR and STAR Kids Member must select a Primary Care Provider (PCP). The role of the Primary Care Provider (PCP) is to provide the following minimum set of primary care services in his/her practice, in conjunction with providing a medical home:

1. Routine office visits
2. Care for colds, flu, rashes, fever, and other general problems
3. Urgent Care within the capabilities of the Physician's office
4. Periodic health evaluations, including Texas Health Steps examinations
5. Well baby and child care
6. Vaccinations, including tetanus toxoid injections
7. Allergy injections
8. Venipuncture and other specimen collection
9. Eye and ear examinations
10. Preventive care and education
11. Nutritional counseling
12. Hospital visits, only if the physician has active hospital admitting privileges and/or if there is a hospital facility available in the immediate geographic area surrounding the physician's office
13. Other covered services within the scope of the Physician Provider's Medical Practice
14. Based on evaluation and assessment, coordinate referrals to in network specialty care
15. Behavioral health screening and help to access care at the request of the Member
16. Provide behavioral health related services within the scope of his/her practice
17. Sign the STAR Kids Physician Order Set and Physician Statement of Need (PSON) when required

The Primary Care Provider (PCP) must provide the services listed above to Driscoll Health Plan CHIP, STAR and STAR Kids Members, unless specifically waived by the Health Plan. In addition to the above services, the PCP is required to:

- Coordinate all medically necessary care with other DHP network providers as needed for each DHP Member, including, but not necessarily limited to:
  - Specialty Care Physicians and ancillary providers
  - outpatient surgery
  - dental care
  - hospital admission
  - other medical services

- Follow DHP procedures with regard to non-network provider referrals (see below) and applicable aspects of the DHP medical management program outlined in "VI – Medical Management" in this manual.
- Be available to Members for urgent or emergency care, either directly or through on-call physician arrangement on a 24 hour-a-day/seven (7) day-a-week basis.
- Have admitting privileges at an in-network hospital.
- Maintain a confidential medical record for each patient.
- Educate Members concerning their health conditions and their needs for specific medical care regimens or Specialty Care Physician referral.
- Help DHP in identifying Members who would benefit from DHP disease management programs and notify DHP of such Members.
- Cooperate with DHP's CHIP/STAR Service Coordination program when Members are determined appropriate for service coordination services, e.g., asthma or diabetes.
- Coordination with Service Coordinators for members identified for disease management in the STAR Kids program.
- Participate in the State of Texas Vaccines for Children Program for the provision of immunization services to pediatric Members.
- Maintain an open panel and accept new Members unless prior arrangements have been made with DHP.
- Be a Texas Health Steps provider and have an acceptable rate of completed Texas Health Steps exams and an acceptable immunization rate evidenced in the State's immunization registry.
- EXCEPTION – OB/GYN Physicians are not required but encouraged to be Texas Health Steps providers.
- Refer Member to Women, Infant, Children (WIC) program and Early Childhood Intervention (ECI) program as appropriate.
- PCP acknowledges that DHP may communicate with their patients/DHP members by text, phone, email or mail. The member has the right to opt out from these DHP communications at any time.

***EXCEPTION**: OB /GYN Physicians are <u>not</u> required but encouraged to participate with the Texas Vaccines for Children Program.*

Other Primary Care Provider (PCP) Responsibilities

The Primary Care Provider (PCP) is responsible for collection of co-payments at the time of service for CHIP Members. DHP CHIP Members are to be responsible for office co-payments and non-covered services (as applicable) at the time of service.

According to the level of CHIP benefits, based on Federal Poverty Level, the amount of a Member's co-payment will vary. The Member's Identification Card will list the co-payments to be collected at the time of service or call CHIP Member Services for help. In no event shall the Member be billed for the difference between billed charges and fees paid by DHP.

***NOTE**: There are currently no co-payments for services for the STAR/STAR Kids Members.*

The PCP is responsible for verifying Member eligibility at the time of the office visit. This includes verification that the Member is seeing the Primary Care Provider (PCP) designated on their DHP Member ID card. If the Primary Care Provider (PCP) office discovers that the Member has dual insurance coverage with a commercial insurance or CHIP/Medicaid, the office is responsible for notifying DHP Member Services.

If the Primary Care Provider (PCP) employs physician assistants, advanced practice nurses, or other individuals who assess the health care needs of the members, the Primary Care Provider (PCP) must have written policies in place that are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

Interpreter/Translation Services

If you have a DHP Member who needs help with special language services or American Sign Language services including interpreters, please call Member Services. DHP is contracted with Pacific Interpreters, who can assist you with interpretation services in your office. Just call **1-866-421-3463** and provide the customer service representative with Pacific Interpreters the following:

- Language needed
- Member DHP ID number
- Physician's first and last name
- Access Code# 80006625

If you need an interpreter in the office when the DHP Member sees you, please call, or have the Member call 48 hours before his/her appointment to schedule these services.

Mental Health and Substance Use Disorder

PCPs and Behavioral Health Providers must work with DHP to be in compliance with parity and comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations.

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 supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

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

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHSC;
- Adult day care centers; 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 with a disability or child residing in or receiving services from one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHAs), Community Center, or Mental Health Facility operated by the Department of State Health Services;
    - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
    - A managed care organization;
    - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; 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 www.txabusehotline.org.

Report to Local Law Enforcement

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

Failure to Report or False Reporting

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

Coordination with Texas Department of Family and Protective Services (DFPS)
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 recognition of abuse and neglect, and the appropriate referral to DFPS.

Who Can Be a Primary Care Provider (PCP)?

The following DHP network provider types are eligible to serve as a Primary Care Provider (PCP) for CHIP, STAR and STAR Kids Members:

- Pediatrician
- Family or General Practitioner
- Internist
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Pediatric and Family Nurse Practitioners (PNP and FNP)
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Obstetricians/gynecologists electing to be a Primary Care Provider (PCP)
- Specialty Care Physicians, as approved by DHP, willing to provide a medical home for specific Members with certain special health care needs or illnesses.

Primary Care Providers (PCPs) and Continuity of Care

DHP requires the provider assist in the transition of care for the following circumstances:

- The HMO must allow pregnant Members with sixteen (16) weeks or less remaining before the expected delivery date to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is out of network. If a Member wants to change her OB/GYN to one who is in network, she must do so if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

- DHP's obligation to reimburse the member's existing out-of-network providers for on-going care does not extend to the following:
  - More than 90 days after a Member enrolls in the HMO's Program, or
  - For more than nine (9) months in the case of a Member who, at the treatment for a terminal illness and remains enrolled in the HMO.
- An out-of-network provider treating a new DHP Member must comply with DHP's Utilization Management Program and accept standard managed care rates. The out- of-network provider must transfer the member's records to the in-network provider.
- DHP will continue to facilitate services for members who move out of the service area until such time that Member is removed from DHP's eligibility.
- Pre-existing conditions do not apply.

Members Right to Designate an OB/GYN

Obstetrician/Gynecologist (OB/GYN): At a minimum, the MCO must ensure that all female Members have access to an OB/GYN in the Provider Network. If an OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP.

Attention Female Members:

Driscoll Health Plan allows members to choose an OB/GYN, but this doctor must be in the same network as the Member's 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
• A referral to a specialist doctor within the network

Do members have the right to choose an OB/GYN?
Members have the right to choose an OB/GYN without a referral from their Primary Care Provider.

How do members choose an OB/GYN?
To choose an OB/GYN, members can contact Member Services at 1-877-324-7543. Members can also choose their OB/GYN as their Primary Care Provider.

If I do not choose an OB/GYN, do I have direct access?
You can have direct access to an OB/GYN doctor. If you are pregnant, Driscoll Health Plan suggests you choose an OB/GYN doctor. An OB/GYN doctor would be able to help you and the baby during your pregnancy.

Will I need a referral?
No, you will not need a referral from your Primary Care Provider to see an OB/GYN doctor.
How soon can I be seen after contacting my OB/GYN for an appointment?
You should be able to get an appointment within two weeks of your request.

Continuity of Care: Members who are pregnant must have access to a Network Provider for prenatal care.
The MCO must allow a pregnant Member who is past the 24th week of pregnancy to remain under the Member's current OB/GYN's care through the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, Out-of-Network.

DHP Members are allowed to self-refer to a network OB/GYN for any of the well-woman services stated above. This information is clearly communicated to the Members in the Member Handbook.

A female CHIP, STAR and STAR Kids Member may designate the OB/GYN physician as her Primary Care Provider (PCP) (excludes STAR Kids Dual Eligible Members). The OB/GYN physician must agree to being designated as the Primary Care Provider (PCP) and must agree to abide by all the Primary Care Provider (PCP) requirement, including but not limited to, being available 24 hours a day, seven days a week. The OB/GYN physician must be part of the DHP network of providers, because DHP limits a Member's selection of OB/GYN physicians to in-network providers.

OB/GYN Responsibilities

Upon initial treatment, the OB/GYN physician must notify DHP immediately of the pregnancy by using one of the following methods:

- Completing the DHP Pregnancy Notification Form (see **Appendix**).
- Completing a similar form containing the required information.
- Telephoning or faxing Service Coordination with the required information.
- Notifying Department for CHIP/STAR Members or STAR Kids Service Coordination.
- Notifying Department for STAR Kids Members with the required information.
- Conduct a post-partum visit between the 21st and the 56th day of delivery.

Providers are not required to use the DHP Pregnancy Notification form itself, but may provide the same information via some other form, such as the American College of Obstetricians and Gynecologists (ACOG) or Hollister high- risk forms or other similar forms. If a health condition is discovered during the self-referral episode of care that is likely to have an ongoing effect on the Member's health and/or the Member's relationship with or care from her Primary Care Provider (PCP), the OB/GYN physician should provide a written report to the Member's Primary Care Provider (PCP) unless the Member specifically requests that no such report be made.

DHP Case Managers for CHIP/STAR Members and Service coordinators for STAR Kids members are available to provide services to high-risk pregnant women, and to be a resource with educational needs. In addition, the Case Managers for CHIP/STAR Members and STAR Kids Service Coordinator for STAR Kids Members would like to be notified of pregnant Members who have positive drug screening results, as frequently these women have premature births, or newborns with complications. If a pregnant Member has a positive drug screen, providers may notify us using the Drug Screening Result Notification form. See **Appendix** for a copy of this form.

You may contact the following if a high-risk pregnant member is identified:

- Service Coordination (CHIP/STAR): **1-877-222-2759**
- Service Coordinator (STAR Kids - Nueces SA): **1-844-508-4673**
- Service Coordinator (STAR Kids - Hidalgo SA): **1-844-508-4675**

OB/GYN physicians must make appropriate referrals for applicable Members to WIC.

Other Specialty Care Physicians as Primary Care Provider (PCP)

From time to time, at the request of a Member or the request of a provider with the Member's permission, and subject to the approval of the Medical Director, a Specialty Care Physician may serve as a Primary Care Provider (PCP) for Members with specific health conditions generally cared for by the Specialty Care Physician. Requests for a Specialty Care Physician to be a Primary Care Provider (PCP) must be submitted in writing, signed by the Member (or parent/guardian if Member is a child) and approved by the Medical Director. Decision will be given to the requesting Specialty Care Physician and Member in writing, within 30 days of original request. If approved, the Specialty Care Physician may serve as a Primary Care Provider (PCP) for specific Members and must be willing to provide all the services outlined above in ***The Role and Responsibilities of the Primary Care Provider (PCP)*** paragraphs of this section, and if they meet the criteria stated below. If denied, the Member may appeal the decision following the appeal process defined in *"STAR & STAR Kids, Section E, Complaints & Appeals"*, or *"CHIP, Section C, Complaints & Appeals"* in this manual.

The Specialty Care Physician that has been chosen as a Primary Care Provider (PCP) by the Member must meet and agree to the following criteria:

1. The Specialty Care Physician must be board certified or board eligible in their specialty and licensed to practice medicine or osteopathy in the State of Texas. (Board certification/eligibility may be waived in certain circumstances for Significant Traditional Providers or providers who have functioned long term in a field that is appropriate for the diagnosis of the Member with special health care needs.)
2. The Specialty Care Physician must have admitting privileges at a network hospital.
3. The Specialty Care Physician must agree to be the Primary Care Provider (PCP) for the Member. He/she will be contacted and informed of the Member's selection. The Specialty Care Physician must then sign the Agreement for Specialist to function as a Primary Care Provider (PCP) form (available by calling Provider Services) for the Member with special needs that has made the request.
4. The Specialty Care Physician must agree to abide by all the requirements and regulations that govern a Primary Care Provider (PCP), including but not limited to:
    a. Being available 24 hours a day, seven days a week,
    b. Administering immunizations as required, and
    c. Acting as the medical home and coordinating care for this Member.

The effective date of the Specialty Care Physician functioning as the Member's Primary Care Provider (PCP) will be the first of the month following the date the Agreement for Specialist to function as a Primary Care Physician form is signed by the Medical Director. Driscoll Health Plan will not reduce the original Primary Care Provider (PCP) compensation owed before the effective date of the Specialty Care Physician functioning as the Primary Care Provider (PCP).

Primary Care Provider (PCP) Panel of Members

Open Panel of Members

DHP desires that all Primary Care Providers (PCPs) maintain an open panel and accept new Members that may select the Primary Care Provider (PCP) for medical care. DHP understands that from time to time a Primary Care Provider (PCP)'s panel will become full and necessitate the PCP to close his or her panel.

Closing Primary Care Provider (PCP) Panel of Members

Primary Care Providers (PCPs) must notify the Provider Relations Department in writing if the PCP's panel needs to be closed. The Primary Care Providers (PCP)'s written notice should include an explanation of why his/her panel needs to be closed. DHP requests that Primary Care Providers (PCP)'s provide at least 30 days' notice of the closure of their panel.

Once the panel is closed, DHP will not allow the Primary Care Provider (PCP) to selectively accept new Members unless the Member or siblings of the Member were existing Members of the PCP.

Reassigning or Freezing of Primary Care Provider (PCP) Panel of Members

DHP reserves the right to reassign Members from one Primary Care Provider (PCP) to another or to freeze a Primary Care Providers (PCP)'s Member Panel, at any time, if it is determined by DHP to be in the best interest of the Member. Reasons a Member may be reassigned or Primary Care Provider (PCP) Member Panel frozen include, but are not limited to, the following:

- The Primary Care Provider (PCP) leaves one group practice to join another group practice which is not part of the DHP network.
- The Primary Care Provider (PCP) temporarily or permanently closes his/her office.
- PCP fails to meet credentialing, quality or accessibility criteria and/or standards.
- The Primary Care Provider (PCP) is under investigation for Waste, Abuse or Fraud.
- Termination of the Primary Care Provider (PCP) Provider Agreement with DHP.
- Other situations as identified by the DHP Credentialing and Peer Review Committee, Executive Quality Committee, Chief Medical Officer (CMO), or Chief Executive Officer (CEO).

Primary Care Provider (PCP) Panel Changes

Primary Care Provider (PCP) Changes

Members have a right to change Primary Care Providers (PCPs). Members can call Member Services to change their Primary Care Provider (PCP). There is no limit on how many times a member can change their Primary Care Provider (PCP).

Members can change their PCP at any time. If a member has seen a PCP in the current month, the change will become effective on the first of the following month. If a member has NOT seen a PCP within the current month, the change is effective right away. A member will be mailed an updated member ID card with new PCP information.

DHP closely monitors Primary Care Provider (PCP) changes because such changes may disrupt the continuity of care and/or may indicate Member dissatisfaction with aspects of their care. DHP will make every attempt to address a Member's concerns prior to their making a Primary Care Provider (PCP) change and may even contact the Primary Care Provider (PCP) for help in resolving the Member's dissatisfaction, if dissatisfaction with the current PCP is the cause for the Member requesting a Primary Care Provider (PCP) change.

Primary Care Provider (PCP) Requested Removal of a Member from Panel

The Primary Care Provider (PCP)'s may request the removal of a Member from their panel in some situations. DHP will work to resolve problems between the Member and the Primary Care Provider (PCP) prior to making the change. The following may be reasons for a Primary Care Provider (PCP) to request that a Member be removed from his/her panel: The member has displayed one or more the following:

- Fraudulent use of services or benefits.
- Threats of physical harm to a provider or the office staff.
- Non-payment of required copayment for services rendered
- Receipt of prescription medication or health services in a quantity or manner, which is not medically beneficial or medically necessary.
- Refusal to accept a treatment or procedure recommended by the provider and such refusal is incompatible with the continuation of the patient-physician relationship. The provider should also indicate if they believe that no professionally acceptable alternative treatment or procedure exists.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan such as frequently missed appointments or abuse of the emergency room.
- Other behavior which has resulted in serious disruption of the patient-physician relationship.

Primary Care Provider (PCP) and Specialty Care Physician Accessibility and Appointment Standards

Accessibility Standards

Primary Care Providers (PCPs) and Specialty Care Physicians must be accessible to Members twenty-four (24) hours a day, seven (7) days a week, either directly or through the provider's delegate. The delegate for the provider must be credentialed by DHP to provide services for the Primary Care Provider (PCP) or Specialty Care Physician. Acceptable after-hours coverage includes that the office telephone:

1. Is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another delegated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. Is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
3. Is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Appointment Standards

Primary Care Providers (PCPs) and Specialty Care Physicians must make appointments available to Members as follows from the date of presentation or request whichever occurs first:

Event	Requirement
Emergency Services	Emergency Services must be provided upon Member presentation at the service delivery site, including at non- network and out-of-area facilities.
Urgent Care, including Urgent Specialty Care and Behavioral Health Services	Urgent care, including urgent specialty care and behavioral health services must be provided within 24 hours. Treatment for behavioral health services may be provided by a licensed behavioral health clinician.
Routine Primary Care	Routine primary care must be provided within 14 days.
Routine Specialty Care	Routine specialty care must be provided within 21 days.
Specialty Therapy Evaluations	Specialty Therapy evaluations must be provided within 21 days of submission of a signed referral. If 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.
Initial Outpatient Behavioral Health Visits	Initial outpatient behavioral health visits must be provided within 14 days. (This requirement does not apply to CHIP Perinate)
Community Long-Term Services and Supports	Community Long-Term Services and Supports for Members must be initiated within seven Days from the start date on the Individual Service Plan as outlined in Section 8.3.4.1 or the eligibility effective date for non-waiver LTSS unless the referring provider, Member, or STAR+PLUS Handbook states otherwise;
Prenatal Care	Prenatal care must be provided within 14 days for initial appointments except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five (5) days, or immediately if an emergency exists. Appointments for ongoing care must be available in

	accordance to the treatment plan as developed by the provider.
Preventive Health Services for Adults	Preventive health services including annual adult well checks for Members 21 years of age or older must be offered within ninety (90) days.
Preventive Health Services for Children, including Well-Child Checkups	Preventive health services for Members less than 6 months must be provided within 14 days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. CHIP Members should receive preventative care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. New Members twenty (20) years of age or younger are encouraged to receive a Texas Health Steps checkups within 90 Days of enrollment. For purposes of this requirement, the term "New Member" is defined in Chapter 12 of the UMCM; and
Case Management for Children and Pregnant Women services	Case Management for Children and Pregnant Women services must be provided to Medicaid Members within 14 Days.

Primary Care Provider (PCP) Referrals to Other Providers

Primary Care Provider (PCP) Referrals to Network Providers

Driscoll Health Plan prefers providers to utilize the Texas Authorization/Referral Form (*see **Appendix** of this manual*) to refer panel Members to Specialty Care Physicians or other ancillary providers for medically necessary services; however, any Texas Medicaid Health Care Partnership Authorization Request Form will be accepted. All forms submitted must be reasonably complete, to include all required essential information elements needed to initiate an authorization referral request, and a copy sent to DHP either by mail, fax, or via the web portal. The contact information is listed below.

CHIP/STAR/STAR Kids Members
Driscoll Health Plan
Utilization Management Department
Acute Prior Authorizations
4525 Ayers Street
Corpus Christi, TX 78415-1401
Fax: 1-866-741-5650
www.driscollhealthplan.com

STAR Kids Members
Driscoll Health Plan
Population Health Department
LTSS Prior Authorizations
4525 Ayers Street
Corpus Christi, TX 78415-1401
Fax: 1-844-381-5437
www.driscollhealthplan.com

Primary Care Provider (PCP) Referrals to Non-Network Providers

In rare situations, the Primary Care Provider (PCP) may believe that the most medically appropriate referral for a specific panel Member with a specific medical condition is to a non- network provider. Referral to non-network providers must be preauthorized by the Medical Director. For preauthorization to make a non-network referral, the Primary Care Provider (PCP) must contact the Utilization Management Department or complete an online referral.

Telemedicine, Telehealth, and Telemonitoring Access

Driscoll Health Plan (DHP) believes that face-to-face visits promote relationships and provide the best interactive care between our Members and their physicians. However, our unique rural Service Areas (SA) often prevent face-to-face interactions and thus DHP supplements with Telemedicine, Telehealth and Telemonitoring to increase access and improve Members' experiences. DHP supports Telemedicine, Telehealth and Telemonitoring services as a critical component of Members' care when face-to-face interactions are not feasible and continues to explore opportunities to enhance our provider network through the use of these services. Our Members can find Providers with Telemedicine, Telehealth or Telemonitoring capabilities by reviewing our Provider Directory which includes relevant information on these capabilities. Information is also provided through newsletters.

Members Right to Self-Referral

DHP Members have the right to make a self-referral for certain services. Unless otherwise specified, self-referral is permitted for CHIP, STAR and STAR Kids Members. Members may self-refer for the following covered services *(in-network only)*:

- Behavioral Health services
- Emergency care
- OB/GYN care
- Family Planning services
- Routine vision care
- A network Ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery

Responsibilities of Specialty Care Physicians

Specialty Care Physicians Responsibilities

Except as outlined above in the ***Members Right to Self-Referral*** paragraphs of this section, Specialty Care Physicians should provide only the services outlined in a valid referral from the Member's Primary Care Provider (PCP) or other authorized provider. Non-network Specialty Care Physicians must have received preauthorization from the Medical Director of DHP.

When providing services pursuant to a valid referral, the Specialty Care Physician is responsible to:

- Provide the services requested in the referral;
- Educate the Member with regard to findings and/or next steps in treatment;
- Coordinate further services with the referring physician or provider and provide such services as authorized;
- Send a written report to the Member's PCP no later than seven (7) working days after the date of service;
- Consult with Member's PCP concerning any additional specialty care or service needed by the Member that is not pre-certified by DHP and/or included with the referral, during or after the Member's visit to the Specialist, prior to providing any additional specialty care or service; and
- Submit a claim for services to DHP within 95 days of the date of service.

If the Specialty Care Physician employs physician assistants, advanced practice nurses, or other individuals who assess the health care needs of the Members, the Specialty Care Physician must have written policies in place that are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, supervision as appropriate, and as further set forth in this Manual and DHP policies and procedures relating to Mid-Level Practitioners.

Before seeing any DHP Member, the Specialty Care Physician is obligated to always:

- Confirm that the Member is an eligible Member and has a valid referral form from the PCP. Adhere to the DHP accessibility standards for obtaining appointments.
- Collect the applicable co-payment for office visit from the CHIP Member (there are currently no co-payments for CHIP Perinate, STAR or STAR Kids Members).

If the Specialty Care Physician's office discovers that the Member has dual insurance coverage with a commercial insurance or CHIP/Medicaid, the office is responsible for notifying DHP Member Services.

If the Member needs mental health or substance abuse services, the Specialty Care Physician may refer to an in-network provider for the mental health benefits. DHP holds individual contracts with Psychiatrists and Therapists to provide these services. Call the Health Services Department at the number below for any questions regarding mental health benefits or the Support Services Department for STAR Kids Members.

Specialty Care Physicians must also comply with all DHP policies and procedures including this Manual.

Hospital Responsibilities

Routine, Elective and Urgent hospital admissions must be pre-authorized. Admissions will be coordinated by the Member's Primary Care Provider (PCP) or a network Specialty Care Physician involved in the Member's care.

Hospital admission for Emergent services should be communicated to DHP within 24 hours of the admission by calling the Health Services Department for CHIP/STAR Members or Support Services Department for STAR Kids Members. The Health Services Department may request certain information be faxed for review.

Ancillary Provider Responsibilities

Ancillary providers such as home health agencies, rehabilitative services providers, DME providers, and similar providers may only provide services as authorized by DHP. It is the responsibility of the referring physician to provide any required physician orders to the ancillary provider.

Credentialing and Responsibilities of Mid-Level Practitioner

Mid-level practitioners include nurse practitioners and physician assistants. Mid-level practitioners who work independently are credentialed by DHP and must:

- Provide an application to the health plan with information identifying the Collaborating Physician who provides oversight.
- Be enrolled in Texas Medicaid Prior to submitting a credentialing application to DHP.
- Ensure that the Supervising Physician providing oversight completes an application and forwards to DHP, so that he/she may complete the credentialing process.
- Supervising Physicians must have current insurance coverage.
- Follow all regulations required by the State of Texas regarding Collaborating Physician oversight.
- Supervising Physician signs the Prescriptive Authority Agreement, or other agreement that complies with the Texas law, understanding the requirement of oversight for the Mid-level practitioner.
- International medical graduates must submit a copy of their certification certificate by ECFMG (Educational Commission for Foreign Medical Graduates) when credentialing with DHP.

Mid-level practitioners may be Primary Care Providers (PCPs), if they meet all the requirements as directed by their Texas licensing board to be an independent practitioner. Questions regarding the practitioner services may be directed to the Providers Services number below.

Marketing Guidelines Affecting Providers

All health plan marketing activities targeting CHIP, STAR and STAR Kids Members must be pre-approved by the Texas Health and Human Services Commission (HHSC). This includes marketing activities by providers that are targeted at CHIP, STAR and STAR Kids enrollees. The following guidelines and prohibitions apply to marketing activities of CHIP, STAR and STAR Kids providers.

Permitted Activities	Prohibited Activities
1. Providers may inform patients about the CHIP and Medicaid Managed Care programs in which they participate. 2. Providers may inform their patients of the benefits, services, and specialty care services offered through the health plans in which they participate.	1. Providers are not allowed to stock, reproduce or handle program enrollment forms. As stated in #6 under permitted activities: ***Providers may distribute and assist members with application forms but may not assist the Member with the enrollment form***. 2. Providers CANNOT help people in filling out the program

Permitted Activities	Prohibited Activities
3. At the patient's request, providers may give patient the information necessary to contact a particular health plan or refer the patient to an MCO member Orientation. 4. Providers may distribute or display written **health educational materials** (see definition below) or health related posters (no larger than 16" by 24") developed by the health plan so long as they do so for ALL health plans in which the provider participates. These materials may have the health plan's name, logo and phone number on them. 5. Providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7" and cannot indicate anything more than "MCO is accepted or welcomed here." 6. Providers may distribute application booklets to families of uninsured children and may help with completing the application. **7.** Providers may direct patients to enroll in CHIP, STAR and STAR Kids programs by calling the state Administrative Service Contractor.	enrollment forms or in making a decision on selecting a health plan. 3. Non-health related materials or banners that are for a specific health plan (even if the provider is contracted with the health plan) are NOT allowed in provider offices. 4. Providers may not make false, misleading or inaccurate statements related to services, benefits, providers, or potential providers of any health plan. 5. Provider may not recommend one health plan over another.

***DEFINITION**: **Health Education Materials** are materials produced by the health plan or a third party that contains information related to health (i.e. immunization, diabetes, heart disease, birth control, prenatal care, Texas Health Steps screens, nutrition, health education classes, etc.) and DOES NOT include announcements of health fairs, materials that are specific to a given health plan, or materials that are specific to CHIP, STAR and STAR Kids Medicaid programs.*

Medical Records

Maintenance of Records

All DHP providers are required to maintain a written or electronic medical record that complies with the standards of the health care industry and with the requirements of applicable federal, state and local laws, rules and regulations. Records must be:

- Individual to each patient a complete and accurate representation of all medical services, counseling and patient education provided by the provider, including ancillary services
- Maintained in an orderly and legible fashion kept secured to ensure the maintenance of confidentiality and be accessible only to practice employees and eligible persons as permitted by law
- Maintained pursuant to procedures of confidentiality that comply with the Health Insurance Portability and Accountability Act (HIPAA)
- Made available to the patient according to the written policies and procedures
- Made available to appropriate parties allowed to view such records pursuant to HIPAA and other relative federal, state and local laws, rules and regulations

Electronic Medical Records

Providers, who use electronic medical recording keeping within their office, must have a system that conforms with all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (collectively referred to as "HIPAA Requirements").

Forms Required by DHP

DHP does not require any health-plan-specific forms to be maintained in a provider's medical records. The forms used by each provider are determined solely by the provider, but must be sufficient to document all treatment, counseling and education services to Members in an orderly, efficient, and complete manner.

DHP and HHSC Requests for Medical Records

DHP and HHSC may request copies of medical records related to the treatment of DHP CHIP, STAR and STAR Kids Members. Such requests for records will generally be for the purposes of (1) assessing or evaluating aspects of the CHIP, STAR and STAR Kids managed care programs, (2) responding to legislative or regulatory inquiries or purposes, (3) responding to complaints or appeals filed by Members or providers, (4) quality improvement and/or utilization management functions, and/or (5) fraud, waste, and abuse monitoring. All providers are required to provide copies of applicable records at no cost to DHP or HHSC if the request comes from:

- HHSC or other federal or state entities of competent jurisdiction.
- DHP as a direct result of a request for records from HHSC or other federal or state entities of competent jurisdiction.
- DHP pursuant to the health plan's utilization management preauthorization's requested by the provider.
- DHP in relation to a quality review.
- DHP or the State as a direct result of a Waste, Abuse and Fraud investigation. See Fraud, Waste and Abuse section for more information regarding medical records

Confidentiality

All providers must maintain written policies and procedures with regard to maintaining the confidentiality of medical records in a manner consistent with federal, state and local laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act. DHP will maintain complete confidentiality with regard to medical records that may be requested from providers. DHP's policies and procedures for confidentiality shall be compliant with applicable federal, state, and local laws, ruled and regulations.

Changes in Provider Address or Contact Information or Opening of New Office Locations

All network providers are required to notify DHP in writing of any changes in office address or in relevant contact information. **Changes in office address should be received by DHP 30 days prior to the change.** This includes notifying DHP when a provider is leaving a group practice or joining another group practice or if an employed provider is leaving a group practice.

In addition, all network providers must notify DHP upon opening of new offices where DHP STAR, STAR Kids or CHIP Members may be treated OR upon engaging new physician or mid- level practitioners who may be involved in the treatment of DHP STAR, STAR Kids or CHIP Members. New PCP office locations may be subject to site review before they are eligible to receive reimbursement.

In addition, all network providers must notify the Health and Human Services administrative services contractor, **Texas Medicaid and Health Care Partnership (TMHP)**, of address or contact information changes.

Cultural Sensitivity

DHP places great emphasis on the whole person care of its members. A large part of quality healthcare delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs, and backgrounds, can improve a provider's relationship with patients and ultimately, the patients' health and wellness. DHP encourages all providers to be sensitive to varying cultures in the community.

Providers must comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

Termination of Provider Participation

Provider Requested Termination

As outlined in each provider's contract, a provider retains the right to terminate his/her participation in the DHP network. **If a provider desires to terminate his/her participation agreement with DHP, a written notice to DHP is required either 90 days prior to the desired effective date of the termination or in accordance with the time frames outlined in the provider's contract with DHP.** DHP will honor requests for termination but may work with the provider to see if some other alternative can be identified to prevent network termination. In the event of a conflict between this rule and the provider's contract, the contract will prevail.

DHP Requested Termination

DHP may terminate a network provider's contract pursuant to relevant state and federal laws, rules and regulations related to provider termination, the DHP Credentialing and Recredentialing Program and Policies or as set forth in the provider's or group's contract with DHP.

Member Materials

DHP sends various communications to members about changes to their benefits and services. All member materials are written at or below a 6th grade reading level to ensure comprehension of the information and distributed in English and Spanish. Members or their representatives may also request materials in audio, larger print, braille and other languages.

Providers are encouraged to provide patient notices and general information about their practice in a similar form.

Community First Choice (CHC)

Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must maintain current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, 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 an Adult Protective Services investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, 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 Adult Protective Services hotline (1-800-252-5400).
- 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.

Privacy and Security/Protected Health Information (PHI)

HIPAA Privacy Regulations

As required by the HIPAA Privacy Rule, providers should have a written policy that outlines the permitted uses and disclosures of patient individually identifiable health information (IIHI) and protected health information (PHI). Providers also need to have an *Authorization For Release of PHI* form which includes all required core elements and statements. Only the member or their legal, authorized personal representative may sign the form, authorizing the release or disclosure of members' PHI. The form needs to include an expiration date, and all core elements and required statements as outlined in 45 CFR 164.508.

Documents with PHI should not be viewable in areas that are accessible to patients. Printed patient health information should be placed in locked cabinets at the end of the day if it is still needed or should be placed in a locked shred bin when ready to dispose. A policy should be in place regarding storage and disposal of medical records. No confidential patient information should be left in the open for patients to see (for example, patient sign-in sheets). Sign-in sheets should never include the patient's medical information (examples: diagnosis or medical problems for which the patient is being seen). If possible, use digital sign in sheets, or sign-in sheets where the patient's name is not visible.

HIPAA Security

To comply with the HIPAA Security Rule, providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, integrity and availability of member PHI and IIHI.

Examples of safeguards include privacy and security training, proper disposal of PHI, password protected computer screens, a policy to address privacy or security violations, procedure for terminating access to PHI when an employee leaves or is terminated, policies for workstation usage and security and role-based access, and audit controls.

Medical identity theft is a rapidly growing problem, and providers' patients trust them to keep their health information private and confidential. Medical identity theft occurs when someone uses a person's name, or other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain healthcare services. Medical identity theft frequently results in erroneous entries in patient medical records. Providers should report any suspected fraud to Driscoll Health Plan.

HIPAA Incident Reporting

Protected Health Information (PHI) HIPAA Incident Reporting

Protected Health Information ("PHI") is information that is transmitted or maintained (held) in electronic, paper or oral form, that identifies an individual (based on 18 possible identifiers), and that relates to a past, present or future physical or mental health condition of that individual. A HIPAA Privacy breach is the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule which compromises the security or privacy of the PHI. Any unauthorized acquisition, access, use or disclosure is presumed to be a breach unless the breach assessment demonstrates a low probability of compromise, or it is determined that a breach exception applies.

If you become aware that Driscoll Health Plan (DHP) member PHI has been lost, stolen, accessed, used or disclosed in an unauthorized manner, notify the Driscoll Health System Chief Privacy Officer immediately upon your discovery to the confidential email address privacy@dchstx.org. Please include the word "Confidential" in the subject line of your email to ensure it is encrypted. Federal HIPAA Privacy law considers a breach as "discovered" as of the first day on which a breach is known to a "covered entity". Healthcare providers are considered covered entities.

Please include the following information in your report:

- Date that the incident occurred
- Date that you discovered the incident
- A general description of the incident
- Information that was disclosed (which of the 18 individual identifiers were disclosed, and/or identifiers disclosed related to the member's health, such as provider name, prior authorization for services, explanation of benefits, plan of care, test or lab results)
- Format in which the information was disclosed (paper or electronic)
- Person(s) to whom it was disclosed
- Whether the information was accessed or viewed
- Mitigations (actions taken that helped mitigate further use or disclosure)
- Best contact email and phone number to reach you if there are any questions

DHP is required under contract with Texas Health and Human Services Commission ("HHSC") to report breaches within 24 hours after the breach assessment is completed. Please refer to the most recent published version of the Uniform Managed Care Contract, Attachment A, Section 11.09 for more details.

Providers may contact the DHP Provider Service Line at
1-877-324-3627 *(for Nueces Service Area*)
Or 1-855-425-3247 *(for Hidalgo Service Area)* for assistance on any provider issues.

Fraud, Waste and Abuse Information

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

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

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

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment

- Letting someone else use their Medicaid
- Using someone else's Medicaid or CHIP ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

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

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us/** "Report Waste, Abuse, and Fraud" to complete the online form;
- Call the DHP WAF Toll Free Hotline Number at **1-844-808-3170**; or
- You can report directly to your health plan:

Driscoll Health Plan
Special Investigative Unit (SIU)
dhpsiu@dchstx.org
5001 N. McColl
McAllen, TX 78504

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

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

- **When reporting about someone who gets benefits, include:**
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud.

Record Requests from DHP SIU

DHP SIU may request copies of medical records related to the treatment of DHP CHIP, STAR and STAR Kids Members to use in audits and/or investigations to monitor compliance and assist in detecting and identifying possible acts of waste, abuse, and fraud by providers. Failure of the provider to supply the records requested by DHP SIU will result in the provider being reported to the Health and Human Services Commission – Office of Inspector General as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold per Texas Administrative Code §353.502(g), Managed Care Organization's Plans and Responsibilities in Preventing and Reducing Waste, Abuse, and Fraud.

SECTION IV

Emergency Services

Definitions: Routine, Urgent and Emergent Services

Routine

Routine care is defined as preventive care, well child visit, Texas Health Steps Medical Check- up visit, or care as routine follow-up for medical management of the Member.

Urgent Care

Urgent care is defined as when a Member needs to be seen, evaluated, and treated within 24 hours. An urgent need may be for illness, or injury that is non-life threatening.

Emergent Care

Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious disfigurement, or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" and "emergency care" includes health care services provided in an in- network or out-of-network hospital emergency department or other comparable facility by in- network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency condition exists.

Some conditions that may require taking the Member to the Emergency Room include:

- Incessant infant crying
- Excessive, uncontrolled bleeding
- Epiglottitis
- High fever
- Pneumonia
- Loss of consciousness
- Kidney stones
- Severe abdominal pain
- Overdose situations
- Mental health conditions where the Member is a threat to himself/herself or others
- Fracture
- Severe laceration
- Status asthmaticus
- Concussion
- Loss of respiration
- Convulsions
- Poisoning
- Chest pain
- Referral from PCP to ER (regardless of diagnosis)

Out-of-Network Emergency Services

Out-of-network emergency services are covered by DHP. Any services rendered are reimbursed per the most recent Texas Administrative Code rules on Managed Care Organization Requirements Concerning Out of Network Providers (Title I Part 15 Chapter 353 Subchapter A Rule 353.4). Members who must use emergency services while out of the service area are encouraged to contact their Primary Care Provider (PCP) as soon as possible and advise them of the emergent situation.

Emergency Transportation

Emergency transportation, such as ambulance services, is covered by DHP. Emergency transportation is defined as transportation to an acute care facility, when there is a life and death situation. Ambulance service companies are to submit claims to DHP for reimbursement.

Emergency Services Outside the Service Area

If a Member is injured or becomes ill while outside of the service area, the Member should contact his/her Primary Care Provider (PCP) and follow his/her instructions, *unless the condition is life-threatening*. If the condition is life-threatening, as determined by a prudent layperson, the Member may go to the nearest emergency facility. The Member should notify DHP of the incident within 48 business hours. In addition, the Primary Care Provider (PCP) should notify DHP within 24 hours or the next Business Day, after learning of the out-of-area emergency. An authorization number will be issued based on medical necessity, for inpatient services. Emergency room services do not require authorization. If the Member is admitted to an out-of-area hospital, the DHP Health Services Department for CHIP/STAR members or Support Services Department for STAR Kids Members, in conjunction with the Primary Care Provider (PCP), will monitor the Member's condition with the out-of-area attending physician. DHP will help the Primary Care Provider (PCP) in arranging a transfer back to the service area when medically appropriate.

STAR & STAR Kids Emergency Dental Services

Medicaid Emergency Dental Services:
DHP is responsible for emergency dental services provided to STAR & STAR Kids Member in a hospital, freestanding emergency room, or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) including but not limited to:

- treatment of a dislocated jaw, traumatic damage to teeth, and supporting structures, removal of cysts;
- treatment of oral abscess of tooth or gum origin; and
- treatment and devices for correction of craniofacial anomalies and drugs.

STAR & STAR Kids Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:
DHP is **not responsible** for paying for routine dental services provided to STAR & STAR Kids Members. These services are paid through Member Dental Managed Care Organizations.

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

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

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

In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier and diagnosis code Z00121 or Z00129 when billing fluoride varnish. The oral evaluation/fluoride varnish must be billed with one of the following medical checkup codes 99381, 99382, 99391, or 99392. This service is limited to six (6) services per lifetime by any provider.

DHP is **responsible** for paying for treatment and devices for craniofacial anomalies.

CHIP Emergency Dental Services

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

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

CHIP Non-Emergency Dental Services

DHP is **not responsible** for paying routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through the Dental Managed Care Organizations.

DHP is **responsible** for paying for treatment and devices for craniofacial anomalies.

SECTION V

Behavioral Health Services

Definition of Behavioral Health

Behavioral Health Services are services for any mental and emotional health disorder, and includes any substance use disorder.

Primary Care Provider (PCP) Requirements for Behavioral Health

Primary Care Provider (PCP) must screen, evaluate, refer, and/or treat any behavioral health problems and disorders. The Primary Care Provider (PCP) may provide behavioral health services within the scope of its practice. PCPs and BH Service Providers should engage in an appropriate level of communication and consultation necessary to properly assess, evaluate, refer, or treat a Member with both a physical health and BH condition. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues.

DHP has a comprehensive network of behavioral health service providers for the treatment of mental health, drug, and alcohol use disorders.

** Excludes STAR Kids Dual Eligible members. DHP STAR Kids Dual Eligible members do not require a designated PCP. See information regarding Health Home in the "Introduction Section" at the beginning of this provider manual.*

DHP Behavioral Health Services Program

Behavioral Health Services are covered services for the treatment of mental and emotional disorders for CHIP (excluding CHIP Perinate Members), STAR (under the age of 21) and STAR Kids Members of DHP. In addition, CHIP, STAR and STAR Kids Members (all ages) may receive treatment for Substance Use Disorders (SUD), as defined by the current Diagnostic and Statistical manual of Mental Disorders (DSM), as a covered benefit. This includes Psychiatric diagnostic interviews (procedure code 90791 or 90792), which are benefits within Texas, when provided by Psychiatrists, Psychologists, Nurse Practitioners, Certified Nurse Specialists, and Physician Assistants, when performed in the inpatient and outpatient setting.

Primary Care Providers (PCP) are responsible for specialized service coordination for Members' physical and behavioral health care, including making referrals to in-network Behavioral Health providers when necessary. In addition, Primary Care Provider (PCP) must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. Primary Care Providers (PCP) may provide behavioral health related services within the scope of their practice. Medical records documentation and referral information (required to document using the most current Diagnostic and Statistical Manual of Mental Disorders [DSM] classifications).

All services which require preauthorization related to behavioral health must be coordinated through DHP. For behavioral health services not covered by STAR and STAR Kids Medicaid, the Member must access local resources. DHP CHIP/ STAR Case Managers and STAR Kids Services Coordinators can help the Member in locating these resources.

A list of local resources for behavioral health care alternatives is available through the following public resources:

- The local Department of Health Services offices
- The local Public Library
- The Finding Help in Texas website: **https://www.211texas.org/211/**

Local Mental Health Authorities (LMHA) facilities treat patients with a primary diagnosis of schizophrenia, bi-polar or major depression, as well as other behavioral health disorders, e.g., (Attention Deficit Disorder [ADD], Attention Deficit Hyperactivity Disorder [ADHD], post-traumatic stress disorder, etc.). The LMHA is required to submit a Mental Health Rehabilitative Services and Mental Health Targeted Case Management Form with the leveling and diagnosis to DHP. No authorization is required for outpatient services.

DHP 24-hour / 7 days a week Behavioral Health Crisis Hotline

Driscoll Health Plan subcontracts for a crisis hotline, which is available 24 hours a day, seven days a week, at the following telephone numbers:

CHIP	STAR Nueces	STAR Hidalgo	STAR Kids Nueces	STAR Kids Hidalgo
1-833-532-0218	1-833-532-0216	1-833-532-0220	1-833-532-0209	1-833-532-0219

These numbers are also listed on the DHP Member's ID card. The crisis hotline provides a Crisis Intervention Specialist who is available to screen the needs of the Member and direct the Member for an initial psychiatric or therapist evaluation. An authorization is not required for initial evaluation. Once Member is seen, it is the responsibility of the contracted provider to fax a completed Texas Referral Authorization Form to the Health Services Department for CHIP/STAR Members and Support Services for STAR Kids Members preauthorization number as listed at the bottom of this page for continued recommended treatment visits.

The following circumstances indicate that a referral to a physician is recommended:

- The Member is receiving psychoactive medication for an emotional or behavioral problem or condition.
- The Member has significant medical problems that impact his/her emotional well-being.
- The Member is having suicidal and/or homicidal ideations.
- The Member has delirium, amnesia, a cognitive disorder, or other condition for which there is a probable medical (organic) etiology.
- The Member has a mental and/or behavioral health disorder due to the use of substances such as substance-induced psychosis, substance induced mood disorder, substance induced sleep disorder, etc.
- The Member has or is likely to have a psychotic disorder, major depression, bipolar disorder, panic disorder, or eating disorder.
- The Member is experiencing severe symptoms or severe impairment in level of functioning or has a condition where there is a possibility that a pharmacological intervention will significantly improve the Member's condition.
- The Member has another condition where there is a significant possibility that somatic treatment would be of help. These conditions include dysthymia, anxiety, adjustment disorders, post-traumatic stress disorders, and intermittent explosive disorders.
- The Member is experiencing a substance use disorder.

Covered Behavioral Health Services

The following services are available to all CHIP (excluding CHIP Perinate Members), STAR and STAR Kids Members:

- Inpatient Substance Use Disorder (SUD) Treatment Services
- Outpatient Substance Use Disorder (SUD) Treatment Services
- STAR and STAR Kids Members Only Mental Health Rehabilitative Services and Mental Health Targeted Case Management

The following services are available to all CHIP Members (excluding CHIP Perinate Members), under the age of nineteen (19) STAR and STAR Kids Members under the age of twenty-one (21):

BH Services including:

a. Inpatient mental health services.
b. Mental Health Rehabilitative Services and MHTCM for individuals who are not dually eligible for Medicare and Medicaid
c. Outpatient mental health services
d. Psychiatry services
e. Collaborative Care Model Services
f. SUD treatment services, including
    i. Outpatient services, such as:
        (1) Assessment
        (2) Detoxification services
        (3) Counseling treatment
        (4) Medication assisted therapy
    ii. Residential services, which may be provided in a CDTF in lieu of an Acute Care inpatient Hospital setting, including
        (1) Detoxification services
        (2) SUD treatment

Behavioral Health Inpatient Facilities must ensure that a seven-day follow-up appointment is scheduled **prior** to Member discharge from an inpatient stay.

Referral Authorizations for Behavioral Health Services

DHP Members do not require referral authorizations for initial evaluation or follow-up behavioral health treatment from an in network Behavioral Health provider. Authorization is required for Psychological testing over eight hours, developmental testing, and inpatient admission. Authorization is required for residential treatment only if the benefit is exceeded. PCP referral is not required for Members to access behavioral health services.

DHP provides medically appropriate and cost-effective services in-lieu-of mental health or substance use disorder services covered by Texas Medicaid. These in-lieu-of services include:

- Partial Hospitalization Program (PHP) Services; and
- Intensive Outpatient Program (IOP) Services.

Authorization is required for these in-lieu-of services.

PCPs may provide Behavioral Health Services for Members, if it is within the scope of his/her practice. A referral for behavioral health services is not required for treatment and management for Members with behavioral health diagnosis.

STAR Kids Dual Eligible members do not require a designated PCP.

Preauthorization

Preauthorization is required for:

- inpatient mental health hospitalizations and dual diagnosis inpatient mental hospitalizations with inpatient detoxification;
- detoxification, chemical dependency rehabilitation, and residential treatment, only if the benefit is exceeded;
- partial hospitalization and intensive outpatient programs; and
- psychological testing over eight hours and developmental testing.

Admission and discharge notification is required for all Residential Treatment Care; however, no authorization is required unless the benefit limit is exceeded.

CHIP/STAR/STAR Kids Utilization Review Case Managers have the authority to approve all situations that meet criteria and refer potential denials or questionable cases to the Medical Director for review. A CHIP/STAR/STAR Kids Utilization Review Case Manager, or a Crisis Intervention Specialists (from the 24/7 Behavioral Health Crisis Hotline), after hours, manages all requests for any treatment that is urgent or emergent. A CHIP/STAR/STAR Kids Utilization Review Case Manager manages all inpatient requests. The Crisis Intervention Specialist from the Behavioral Health Hotline *(phone numbers listed above under "DHP 24-hour / 7 days a week Behavioral Health Crisis Hotline")* has the authority to provide referral information to an inpatient facility, depending on the crisis situation, and their telephone evaluation.

Prior authorization may be obtained by the provider faxing a preauthorization request form to the Utilization Management Department for CHIP/STAR/STAR Kids Members prior to testing being initiated (see the fax number listed at the bottom of this page). The provider may also submit a request via the provider web portal.

Triage and Initial Assessment

DHP has clinicians available 24 hours a day, seven days a week, to help Members with referrals to practitioners, facilities, urgent or emergent care and crisis calls. DHP CHIP/STAR/STAR Kids Utilization Review Nurse, STAR Kids Support Services UR nurse or Qualified Mental Health Professional (through the Behavioral Health Crisis Hotline) helps Members with clinical recommendations, urgent and emergent care, crisis calls and referrals to facilities. The goal of the referral and triage process is to provide accurate information and referrals to appropriate providers.

Utilization Management

Utilization review includes a system for prospective, concurrent, and retrospective review to determine the medical necessity and appropriateness, and the experimental or investigational nature of health care services.

STAR/CHIP Service Coordination

DHP CHIP/STAR Service Coordination addresses a Member's longitudinal course of care including continuity and coordination among providers for both behavioral health and physical health. DHP CHIP/STAR Service Coordination includes helping Members to access behavioral health care within the most efficient time frame by the most appropriate practitioner or in the most appropriate treatment setting. Our service coordinators help our Members complete a seven and 30-day follow-up appointment after a behavioral health inpatient stay. It is necessary to promote the efficient use of benefits to maximize Member and family access to care. In addition, DHP has implemented intensive service coordination for Members who have been identified as high-risk due to diagnosis, inpatient admissions, or a history of self-harm or who require additional services and have complicating factors that, without intensive intervention, would result in further deterioration in the severity of illness.

STAR/ CHIP Service Coordinators will screen member for individual needs, enroll in care coordination program, and develop an individual, person-centered service plan with collaboration and input from the PCP, specialist, member, LAR, and/or family member/support. The Service Coordinator may refer to other providers or community-based organization as needed to meet the member's needs.

Members can reach STAR/CHIP Service Coordinators by calling Population Health: **1-877-222-2759** STAR Kids Members will have a service coordinator available to facilitate continuity of care and coordination of care services (see STAR Kids Section of this manual for additional information).

Utilization Decisions

Consistency of Application of UM Criteria

DHP uses InterQual Criteria for all inpatient and ASAM Criteria powered by Interqual for Residential Treatment Center Substance Use Disorder utilization management decisions. The criteria are used by utilization review staff and by the Medical Director. All preauthorization, concurrent and retrospective review decisions as well as appeal determinations will reference the appropriate medical necessity criteria and indicate why the criteria were met or not met.

Denials

The Associate Behavioral Health Medical Director or his designee reviews all potential denials related to behavioral health diagnoses. A physician makes all medical necessity denial determinations. The Medical Director may contact the provider requesting services for additional information or to discuss alternatives to care. The provider requesting services may request to consult with the Medical Director.

Peer-to-Peer Conversation

Peer-to-Peer conversations related to non-certification decisions are available to Providers, pre and post determination, and are the most timely and direct process to facilitate exchange of information in support of the authorization process. Peer Clinical Reviewers are available to discuss non-certification decisions with Attending Providers or other Ordering Providers via the toll free UM line at 1-877-455-1053 (CHIP/STAR/STAR Kids) or 1-844-406-5437 (STAR Kids LTSS) during normal business hours Monday - Friday from 8 a.m. to 5 p.m., except for legal holidays.

Peer-to-Peer Availability Prior to Decision

DHP affords the treating Health Care Provider with a reasonable opportunity to discuss the Member's treatment plan and the clinical basis of a non-certification decision with the original Peer Reviewer prior to issuing an adverse determination. The definition of reasonable opportunity timeframe is as follows:

- One (1) business day for a routine, prospective review;
- Five (5) business days for a retrospective review; and
- Prior to issuing, for a concurrent or post-stabilization review.

If the original Peer Reviewer cannot be available within one (1) business day, another Peer Reviewer will be available for the conversation.

Peer-to-Peer Post-Decision

When DHP makes a non-certification decision, and no peer-to-peer conversation has occurred in connection with the case, DHP provides, within one (1) business day of a request by the Attending Provider or Requesting Provider, the opportunity to discuss the non-certification decision:

a. With the Clinical Peer Reviewer making the initial determination; or
b. With a different Clinical Peer, if the original Clinical Peer Reviewer cannot be available within one (1) business day.

For CHIP, STAR, and STAR Kids non-certification decisions, the Peer-to-Peer Conversation Availability Form is sent via facsimile and/or the provider or facility receives notification via phone. Additionally, peer-to-peer offer for non-certification decisions is included in the *Notification of Referral Status* facsimile.

For STAR or STAR Kids members less than 21 years of age, the peer-to-peer offer is also in the Initial Request for Additional Information letter.

If a peer-to-peer conversation or review of additional information does not result in an authorization (certification), DHP informs the Provider and Member of the right to initiate an appeal and the procedure to do so.

Appeals

For more information regarding appeal process, contact Provider Services at the phone number below, or refer to *"STAR & STAR Kids, Section E, Complaints & Appeals", or "CHIP, Section C, Complaints & Appeals"* in this manual.

Responsibilities of Behavioral Health Providers

Behavioral Health providers and/or physical health providers, who are treating a behavioral health condition, are responsible for appropriate referrals to the Family and Protective Services for suspected or confirmed cases of abuse. Health information must be shared securely, efficiently, and effectively between Members' PCP and BH Providers. Behavioral Health Providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Reporting Abuse, Neglect, or Exploitation (ANE):

DHP, its subcontractors, and Providers must report any suspicion or allegation of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. DHP contracts include DHP and provider responsibilities related to identification and reporting of ANE. Additional state laws related to DHP and provider requirements continue to apply. 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. Reports can be made by calling Texas Abuse Hotline number at **1-800-252-5400** or online at: **wsww.txabusehotline.org**.

They are also responsible to assure that any necessary preauthorization takes place and for the following:

- Assure the release of information consent form is signed by the Member.BH Service Providers and PCPs are required to send each other initial and updated summary reports of a Member's physical and BH status, as agreed to by the PCP Team members.
- PCP's are required to screen Members for any BH condition and may treat Members within the appropriate scope of their practice and refer Members for treatment through the Provider Network
- Refer Members with known or suspected physical health problems or disorders to the Primary Care Provider (PCP) for examination and treatment.
- Only provide physical health if a physical health provider is already providing behavioral health care.
- Ensure that its patients know their rights to execute Behavioral Health Advance Directives.
- Assure all CHIP, STAR and STAR Kids Members that receive inpatient psychiatric services are scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge.
- Have policies and procedures in place on how to follow up on Members' missed appointments.
- Contact Members who have missed appointments within 24 hours to reschedule appointments.
- Make available to Primary Care Provider (PCP) behavioral health assessment instruments.
- Communicate with the Member's Primary Care Provider (PCP), if approved by the Member, treatment plans and progress to achieving treatment plan.
- Refer the Member for needed lab and ancillary services if not available in the provider's office.
- Ensure that STAR and STAR Kids Medicaid Members have access to the full continuum of covered services for substance use disorder, as medically necessary. This includes coordination with the Department of State Health Services (DSHS), Department of Family and Protective Services (DFPS), and their designees.

7-day and 30-day Follow-up after Inpatient Behavioral Health Admission

Providers must ensure Members must have scheduled seven-day follow-up appointments at time of discharge from an inpatient Behavioral Health admission. They should also have a 30-day follow-up from date of discharge. These follow-up appointments are monitored by the Executive Quality Committee, as well as through Health and Human Services Commission (HHSC). Behavioral Health providers need to ensure that these appointments are scheduled and kept. Members who miss appointments are attempted to be contacted to reschedule. STAR Kids Services coordinators communicate with STAR Kids Members who miss appointments and provide follow up to reschedule the missed appointment.

Members with behavioral health diagnosis are also monitored for readmission to inpatient facility. Results of these reports and focused studies are available to providers upon request.

DSM-IV Coding Requirements

Behavioral health documentation and referral requests should include a primary and secondary (if present) diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM). Subsequently, behavioral health claims should be filed using the applicable and appropriate DSM diagnostic code to define the patient's condition being treated.

Laboratory Services for Behavioral Health Providers

Behavioral Health providers should facilitate provision of in-office laboratory services for behavioral health patients whenever possible, or at a location that is within close proximity to the Behavioral Health provider's office. Providers may refer Members to any network independent laboratory for needed laboratory services.

Court-ordered Services and Commitments

Driscoll Health Plan (DHP) provides covered Medicaid inpatient psychiatric services to Members birth through age 20, and ages 65 and older, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction including services ordered pursuant to 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. For individuals between the ages of 21 and 64, DHP may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting. DHP cannot deny, reduce, or controvert the Medical Necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members birth through age 20 or ages 65 and older. **DHP does not require authorization for court-ordered services.** Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under a Court-Ordered Commitment can only Appeal the commitment through the court system. DHP must provide Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.

Consent for Disclosure of Behavioral Health Information

The provider is required to obtain consent for disclosure of information from the Member in order to permit the exchange of clinical information between the Behavioral Health provider and the Member's Primary Care Provider (PCP).

If the Member refuses to sign a release of information, documentation will need to indicate that the Member refused to sign. In addition, the provider will document the reasons for declination in the medical record.

SECTION VI

Utilization Management

Utilization Management Program

Utilization Management is a set of activities performed by Driscoll Health Plan (DHP) to ensure that appropriate, medically necessary services are available to and coordinated for Members in an efficient and timely manner, at the appropriate level, and in the appropriate setting and to determine whether services are experimental or investigational in nature. The UM Program monitors over and under-utilization of both inpatient and outpatient services and provides feedback on performance to the health plan. It employs a combination of prospective, concurrent, and retrospective review of clinical data. Registered Nurses, Case Managers and Clinicians under the supervision of the Medical Director perform all Utilization Management activities.

Philosophy of Utilization Management

The goals of the Utilization Management Program are:

- Assure access to appropriate levels of care;
- Promote disease prevention and wellness;
- Provide high quality, cost-effective services for all Members; and
- Provide for Member and Provider satisfaction.

We strive to assure that the Member is receiving the appropriate care at the appropriate time and work proactively on the Member's behalf with the DHP network Providers, to ensure the Member is maintaining his/her optimal level of health and well-being.

Communication with Utilization Management

Access to Review Staff

Driscoll Health Plan (DHP) serves Texas counties in the Central Time Zone only. The CHIP/STAR/STAR Kids Utilization Management (UM) Department and STAR Kids Long Term Support Services (LTSS) Department are available Monday - Friday, 8 a.m. to 5 p.m. CST, excluding legal holidays, to respond to utilization review inquiries.

Review Service Communication and Time Frames

Hours to receive communications:

DHP receives communications from Providers and Members during both the business day and after business hours. Mechanisms for receipt of communications include telephone, facsimile, provider portal, and USPS mail. Providers can submit requests for inpatient or outpatient authorization 24 hours a day, seven days a week at the following numbers and website:

CHIP/STAR/STAR Kids UM

Fax:	**1-866-741-5650**
Inpatient Fax:	**1-833-808-2175**
Phone:	**1-877-455-1053**
Web:	**www.driscollhealthplan.com**

STAR Kids LTSS

Fax:	**1-844-381-5437**
Phone:	**1-844-376-5437**
Web:	**www.driscollhealthplan.com**

Calls received after business hours: An after-hours recording prompts the caller to select the option for nurse on call, who is available 24 hours a day, seven days a week, for calls received after hours.

Trained personnel staff the Mental and Emotional Health Services Hotline (Avail Solutions) 24 hours a day, seven days a week, toll-free throughout the service area.

Response to communications:
DHP responds to communications within one (1) business day, messages received after business hours on the next business day, and voice mail messages within one (1) business day.

Outgoing communications:
DHP conducts its outgoing communications related to UM during Providers' reasonable and normal business hours, unless otherwise mutually agreed.

Preauthorization

Overview

Driscoll Health Plan (DHP) requires preauthorization of certain services. DHP uses the preauthorization process to evaluate the medical necessity of a procedure or course of treatment, appropriate level of services, and the length of confinement prior to the delivery of services. The supporting clinical information provided aids in the medical review of the request.

Providers must submit requests for services that require preauthorization to the health plan UM Department or Population Health (STAR Kids LTSS) Department prior to rendering services. Failure to obtain preauthorization may result in non-payment of claims.

The Medical Director will make any denial of preauthorization based on lack of medical necessity or documentation of such. Members and Providers receive written notification of all denials that are the result of lack of medical necessity. Denial notifications include the reason for the denial and instructions for requesting an appeal.

Clinical Review Criteria

DHP Medical Management will utilize InterQual review criteria in the process of managing utilization for prospective, concurrent, and retrospective review. Clinical peer reviewers may additionally utilize other criteria and evidence based guidelines, such as The American College of Obstetrics and Gynecology (ACOG), The American Academy of Pediatrics (AAP), The American Medical Association (AMA), Texas Health and Human Services Commission (HHSC) and Driscoll Health Plan policy. DHP may develop its own clinical review criteria where the medical director determines existing clinical review criteria to be inadequate.

For LTSS Services, the STAR Kids Screening and Assessment Instrument (SAI) performed by the Service Coordinator will determine medical necessity for the LTSS services. Any DHP actions or intended actions will require a written notification to the member describing the action.

Results of Not Obtaining Preauthorization

When Providers do not obtain preauthorization for services that require preauthorization, these services are subject to denial.

Peer-to-Peer Conversation

Peer-to-Peer conversations related to non-certification decisions are available to Providers, pre and post determination, and are the most timely and direct process to facilitate exchange of information in support of the authorization process. Peer Clinical Reviewers are available to discuss non-certification decisions with Attending Providers or other Ordering Providers via the toll free UM line **at 1-877-455-1053 (CHIP/STAR/STAR Kids)** or **1-844-406-5437 (STAR Kids LTSS)** during normal business hours Monday - Friday from 8 a.m. to 5 p.m., except for legal holidays.

Peer-to-Peer Availability Prior to Decision
DHP affords the Provider with a reasonable opportunity to discuss the Member's treatment plan and the clinical basis of a non-certification decision with the original Peer Reviewer prior to issuing an adverse determination. The definition of reasonable opportunity timeframe is as follows:

- One (1) business day for a routine, prospective review;
- Five (5) business days for a retrospective review; and
- Prior to issuing, for a concurrent or post-stabilization review.

If the original Peer Reviewer cannot be available within one (1) business day, another Peer Reviewer will be available for the conversation.

Peer-to-Peer Post-Decision Conversation
When DHP decides to issue a non-certification decision, and no peer-to-peer conversation has occurred in connection with the case, DHP provides, within one (1) business day of a request by the Attending Provider or Requesting Provider, the opportunity to discuss the non-certification decision (see **Appendix D**):

c. With the Clinical Peer Reviewer making the initial determination; or
d. With a different Clinical Peer Reviewer, if the original Clinical Peer Reviewer cannot be available within one (1) business day.

For CHIP, STAR and STAR Kids non-certification decisions, the *Peer-to-Peer Conversation Availability* form is sent via facsimile and/or the provider and/or facility receives notification via phone. Additionally, peer-to-peer offer for non-certification decisions is included in the *Notification of Referral Status* facsimile.

For STAR and STAR Kids Members less than 21 years of age, the peer-to-peer offer is also included in the *Initial Request for Additional Information/Insufficient or Incomplete/Lack of Information* letter

If a peer-to-peer conversation or review of additional information does not result in an authorization (certification), DHP informs the Provider and Member of the right to initiate an appeal and the procedure to do so.

Appeals
Members may request reconsideration of determinations in accordance with the medical appeals process. For more information regarding how to appeal and the appeal process, contact Provider Services at the phone number below, or refer to "*STAR & STAR Kids, Section D, Complaints & Appeals"*, or *"CHIP, Section D, Complaints, Peer to Peer Conversation & IRO Processes"* in this manual.

Referrals
Requesting a Referral via the Internet
The preferred method of submission is via the Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**. Provider offices with internet access have received instruction on how to use the Provider Portal. Provider offices interested in additional information on entering web-based referrals can call Provider Services at the phone number listed at the bottom of this page for detailed instructions on this process.

Requesting a Referral via Phone or Fax
DHP also accepts authorization referral requests via phone or fax. DHP prefers providers to utilize the Texas Authorization and Referral Form (see **Appendix** of this manual) to request preauthorization for medically necessary services; however, any Texas Medicaid Health Care Partnership Authorization Request Form will be accepted. All forms submitted must be complete. Providers may fax the request to the UM Department or STAR Kids LTSS Department.

Obtaining Referral and Authorization Forms
Forms are available online as well as from the Utilization Management Department.

Requesting a Referral

The Provider (Primary Care Provider (PCP), Specialty Care Provider or Facility) initiates a preauthorization for referrals via the Provider Portal on the internet, or via phone or fax. Referrals to in-network Providers and Facilities are preferred when services are available within network.

Providers must include the following essential information listed below when submitting preauthorization referral requests for services to initiate the preauthorization referral:

- Member name;
- Member's birth date;
- Member's CHIP, STAR and STAR Kids Medicaid Identification Number;
- Requesting Provider name;
- Requesting Provider National Provider Identifier (NPI);
- Procedure codes (Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS));
- Quantity requested (number of visits or units requested); and
- Service start and end dates.

DHP will reject preauthorization referral requests missing essential information by faxing back the requesting Provider with a list of what is missing and the essential information to provide. Providers will need to resubmit the preauthorization referral request with all of the necessary essential information included.

To expedite processing of the preauthorization referral request, it is beneficial for Providers to include the Diagnoses and clinical information and documents to support medical necessity of the request with the essential information listed above (see the DHP Authorization Requirement Portal website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing). DHP will initiate the Insufficient Lack of Information Process if it is determined clinical information or documents to support medical necessity are lacking.

DHP will review all requests for services. DHP will approve requests that meet clinical criteria and are determined medically necessary. A referral authorization number will be assigned. DHP will refer the request for services that fail to meet clinical criteria to the Peer Clinical Reviewer for review.

Referral Procedure

Primary Care Provider (PCP) Referrals to Specialty Care Providers

Primary Care Provider (PCP) usually initiate a Member's referral request during an office visit. Referral requests usually include visits to the Specialty Care Provider, Ancillary Provider or Facility through the Member's enrollment period.

Prior to the visit to the Specialty Care Provider, Ancillary Provider or Facility (with the exception of Emergency Room and Behavioral Health initial evaluation), a referral authorization should be issued.

No preauthorization is required for referral requests from PCP to PCP or PCP to Specialty Care Provider for office visits (E&M codes) to in-network Providers.

PCPs must refer to in-network Providers if services are available. DHP will forward requests for services to an out-of-network Specialty Care Provider to the Peer Clinical Reviewer for review.

The following steps should be taken when a referral to a Specialty Care Provider, Ancillary Provider or Facility is necessary:

- The PCP selects a Specialty Care Provider, Ancillary Provider or Facility from the DHP physician panel;

- The PCP arranges for services with the Specialty Care Provider, Ancillary Provider or Facility in the usual manner including coordination of pertinent clinical information and then submits a preauthorization referral request for services; and
- The PCP submits a preauthorization referral request utilizing the Texas Authorization and Referral Form (TARF) (see **Appendix** of this manual) or online via the DHP Provider Portal on the internet.

Once the referral request is submitted to DHP and approved, both the Requesting and Referred Providers or Facility (the PCP, as well as the Specialty Care Provider, Ancillary Provider or Facility), will receive a confirmation via fax that DHP has approved the request. The faxed *Notification of Referral Status* document will contain the referral authorization number. (Authorization of services does not guarantee payment.)

The Specialty Care Provider, Ancillary Provider or Facility will examine and treat the Member (as requested by the PCP) and document recommendations and treatment. The Specialty Care Provider, Ancillary Provider or Facility should keep the PCP continually informed of findings and treatment plans.

The Specialty Care Provider, Ancillary Provider or Facility will submit a claim form, accompanied by the authorization number, to DHP. For further details regarding claim filing, please see "*VIII – Billing and Claims*" in this manual.

If the Member requires additional services not directly associated with the requested services and diagnosis listed in the existing referral, the Specialty Care Provider must then contact the UM Department or STAR Kids LTSS Department for preauthorization.

Members with Special Health Care Needs
Members with special health care needs may need several referrals to meet their health care needs. These Members may need direct access to a Specialty Care Provider. Members with special health care needs may have a standing referral to a Specialty Care Provider as approved by the Peer Clinical Reviewer/Medical Director.

Specialty Care Physician to Specialty Care Physician Referrals
Specialty Care Providers may refer to another Specialty Care Provider if the Specialty Care Provider is in-network and the referral is for the same diagnosis.

Specialty Care Providers may not refer to another Specialty Care Provider if the referral is for a different diagnosis. When a Specialty Care Provider wishes to refer to another Specialty Care Provider for a different diagnosis, he/she must refer the Member back to the PCP to initiate the Physician-to-Physician referral request.

Specialty Care Providers can refer patients for ancillary services that fall under the scope of their practice. (For example, an Orthopedic Specialty Care Provider can make a referral for Physical Therapy or Occupational Therapy.) Specialty Care Providers should inform the PCP of the results of any examinations and any additional treatment recommended.

Self-Referral Services
Members may self-refer, without a Primary Care Provider (PCP) referral, for the following services:

- Emergency care;
- Routine vision Care;
- OB/GYN care;
- Behavioral Health Services;
- Texas Health Steps medical checkups;
- Family Planning (STAR Members only); and
- A network Ophthalmologist or therapeutic optometrist to provide eye Health care services, other than surgery.

Out-of-Network Referrals
Request for services by non-participating, non-contracted providers, or out of area/out of network services require preauthorization by the UM Department or Population Health (STAR Kids LTSS) Department. The preauthorization will require that the requesting provider submit to DHP rationale for requesting services out-of-network.

Provider-Requested Second Opinions and Member-Requested Second Opinions
All members are entitled to a second opinion. Second opinions requested by either the Member or the Provider require preauthorization. For information regarding second opinion requests, contact the UM Department or STAR Kids LTSS Department.

Eligibility Issues and Late Notification for Prior Authorization

Outpatient Services

DHP Member Coverage Unknown	Retro-Enrollment and assignment to DHP
Where prior authorization was required and DHP coverage is identified after services are rendered, authorization is required prior to claims submission. DHP will conduct retrospective review of medical necessity for the services rendered without penalty for late notification if the reason provided is substantiated in the request for authorization.	Where prior authorization was required and retro assignment to DHP is identified after services are rendered, authorization is required within 30 days of the retro assignment date and prior to claims submission. DHP will conduct retrospective review of medical necessity for the services rendered without penalty for late notification if indication of retro-assignment as reason for late notification is provided and substantiated in the request for authorization.

Inpatient Services

DHP Member Coverage Unknown	Retro-Enrollment and assignment to DHP
If DHP coverage was unknown upon admission, and identified during the stay, authorization is required. DHP will process the authorization request without penalty for late notification if the reason for late notification provided is substantiated in the request for authorization.	If retro-assignment to DHP is identified during the stay, authorization is required within 30 days of the retro-assignment date. DHP will process the authorization request without penalty for late notification during this timeframe. Indication of retro-assignment as reason for late notification must be provided with the authorization request.
If DHP coverage identified post discharge but prior to claim submission, authorization is required prior to claims submission. DHP will conduct retrospective review of the stay without penalty for late notification if the reason for late notification provided is substantiated in the request for authorization.	If retro assignment to DHP is identified after discharge and prior to claim submission, authorization is required within 30 days of the retro-assignment date and prior to claims submission. DHP will conduct retrospective review of the stay without penalty for late notification. Indication of retro-assignment as reason for late notification must be provided with the authorization request.

Providers may notify DHP of any above scenario in one of the following manners:

- Via the DHP Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**, by entering a note on the referral;
- Via facsimile, by entering a comment on the cover sheet or authorization request form, toll free 1-866-741-5650; or

- Via telephone call to the DHP UM department, toll free 1-877-455-1053.

Providers are responsible for verifying member's eligibility. Eligibility can be verified via:

- DHP Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**;
- DHP's automated IVR system (1-877-324-3627); or
- Calling Customer service and speaking with a Customer Service Representative (1-877-324-3627)

Prospective, Concurrent, and Retrospective Reviews and Determination Timeframes

Prospective and Concurrent Review Determinations

For prospective review and concurrent review, DHP bases review determinations solely on the medical information obtained by DHP at the time of the review.

Prior to elective hospital admissions or outpatient surgical procedures, Driscoll Health Plan (DHP) UM Case Manager and DHP Peer Clinical Reviewer performs pre-admission review and screening for appropriateness of admission and setting of care. The UM Case Managers are responsible for collecting data from the Providers' offices, Member, and/or Facility regarding anticipated length of stay and discharge planning needs.

To improve patient safety and reduce medical errors, DHP has implemented a mechanism to address potential safety and quality issues identified during prospective and concurrent review through to resolution. DHP screens referral requests for potential safety and quality concerns including, but not limited to, contraindicated treatment, conservative treatment not addressed or ruled out, adverse drug reactions, and/or inappropriate treatment.

Prospective Review

Prospective review is the process of reviewing requests for health care services before the member's admission, stay, or other service or course of treatment. The functions of prospective review include:

a. Verification of eligibility and plan benefits;
b. Verification of medical necessity;
c. Determination of appropriate level and setting of care;
d. Determination of appropriate length of stay, if applicable;
e. Pre-certification of inpatient admissions;
f. Preauthorization of certain ambulatory services;
g. Initiation of Disease Management/Service Coordination, where applicable;
h. Authorization of specialty referrals;
i. Identification of any aberrant practice patterns and submit to the CHIP/STAR/STAR Kids UM Manager or STAR Kids LTSS Manager; and
j. To ensure patient safety and report suspected issues as appropriate.

Concurrent Review

Concurrent review is the process of reviewing inpatient/observation health care services while rendered to ensure that:

a. Scheduled and unscheduled admissions are medically necessary and appropriate level and setting of care;
b. Continued stay is medically necessary;
c. Cases in which the admission is greater than twenty-one days are presented and reviewed at weekly Interdisciplinary Team (IDT) Meetings consisting of the Medical Director, Case Managers, Social Workers, and STAR Kids LTSS Service Coordination; and
d. To ensure patient safety and report suspected issues as appropriate.

In addition to the items listed above, other functions of concurrent reviews include:

a. Verify that care is coordinated among all disciplines;
b. Identify and refer problematic cases to Disease and Case management/Service Coordination;
c. Initiate timely discharge planning activities; and
d. Trigger referrals to Quality Management and Social Services.

Retrospective Review Determinations

Retrospective review is the process of reviewing appropriateness and medical necessity of health care services after delivery to the member. For retrospective review, DHP bases review determinations solely on the medical information available to the Attending Provider or Ordering Provider when he/she provided the medical care, including both inpatient and outpatient medical necessity reviews when a certification is required.

Retroactive Enrollments:
DHP will perform concurrent review of referral requests for retroactively enrolled DHP members, if hospitalized, and remains admitted, at the time of the retroactive enrollment notification to DHP. Providers must provide written or electronic admission notification to DHP UM Department within 30 days of TMHP ADD date.

DHP will perform retrospective review of referral requests for retroactively enrolled DHP members, if discharged at the time of the retroactive enrollment notification to DHP. Providers must provide written or electronic admission notification to DHP UM Department within 30 days of TMHP ADD date.

Time Frames for Initial Determinations

DHP shall issue a determination within the following timeframes (in compliance with state regulatory requirements) for each of the three general categories of utilization management review: prospective, concurrent, and retrospective.

Prospective Review Time Frames

- *Urgent Care*
  As soon as possible based on the clinical situation, but no later than 24 hours from receipt of a preauthorization referral request for a UM determination.

- *Routine/Non-Urgent*
  a. All CHIP requests submitted with complete supporting clinical information and documentation: Within two (2) business days (for approvals) and within three (3) business days (for adverse determinations) from the receipt of a preauthorization referral request for a UM determination.
  b. Non-emergent ambulance services requests for STAR/STAR Kids and all other STAR/STAR Kids requests submitted with complete supporting clinical information and documentation: Within three (3) business days from the receipt of a preauthorization referral request for a UM determination.
  c. STAR and STAR Kids members of all ages lacking supporting clinical information and documentation: For a request for a UM determination that is lacking supporting clinical information and documentation, see the Insufficient Lack of Information Process below.

- *Life-threatening Conditions or Post-Stabilization Care*
  a. **Certification (authorization) is not required for Emergency Care.** "Emergency care" means health care services provided in a Hospital Emergency Facility or comparable Facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Member's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:
     - Place the Member's health in serious jeopardy;
     - Result in serious impairment to bodily functions;
     - Result in serious dysfunction of a bodily organ or part;
     - Result in serious disfigurement; or

- For a pregnant woman, result in serious jeopardy to the health of the fetus.

b. Within one (1) hour from the receipt of a preauthorization referral request for a UM determination related to post-stabilization care subsequent to emergency treatment.
   - Post Stabilization: DHP will perform initial review and make a decision regarding post-stabilization care subsequent to emergency treatment within the time appropriate to the circumstances relating to the delivery of the services to the Member and the Member's condition. When denying post stabilization care subsequent to emergency treatment, DHP will provide the notice to the treating Provider or other Health Care Provider no later than one hour after the time of the preauthorization referral request.

Concurrent Review Time Frames

Inpatient and Observation Admissions:

DHP issues a determination of an authorization referral request for inpatient or observation level of care admission, with respect to a Member who is hospitalized at the time of the request, within one (1) business day of receipt of request (with all supporting documentation) or identification of a need to extend.

Requests to extend a current course of treatment:

DHP will issue a determination, if practicable, before the existing authorization referral expires. DHP allows for timely submission of continuation of service requests/renewal of an existing prior authorization up to 60 days before the current prior authorization expires. For some services, it is not practicable to prior authorize a new course of treatment 60 days prior to the end date of the current prior authorization period as these services may require documentation, to include assessments and provider or therapy progress notes, more recent than 60 days prior to the end date of the current prior authorization. When this occurs, DHP provides notification to the provider to resubmit the continuation of service/prior authorization recertification request, with supporting documentation, closer to the end date of the current prior authorization.

Per state regulatory requirements, when DHP receives preauthorization referral requests to extend a current course of treatment for cases involving urgent care at least 24 hours before the expiration of the currently certified period of treatment, DHP will issue a determination within 24 hours of receipt of the request for extension. When DHP receives preauthorization referral requests to extend a current course of treatment for cases involving urgent care less than 24 hours before the expiration of the currently certified period of treatment, DHP will issue a determination within one (1) business day or 72 hours (whichever is sooner).

Reductions or terminations of a previously approved course of treatment:

DHP issues the determination early enough to allow the Provider and Member to request a review and receive a decision before the reduction or termination occurs, but no longer than one (1) business day (with all supporting documentation). For termination, suspension, or reduction of a previously approved course of treatment, DHP sends notification via USPS mail and facsimile at least 15 calendar days prior to the termination, suspension, or reduction.

Retrospective Review Time Frames

DHP will issue a determination within 30 calendar days from the receipt of preauthorization referral request for a retrospective UM determination.

Frequency of Continued Reviews

DHP UM Case Managers or STAR Kids LTSS Service Coordinators shall conduct continued reviews for the extension of an initial determination with a frequency based solely on the severity and complexity of the patient's condition, or on necessary treatment and discharge planning activity. DHP UM Case Managers or STAR Kids LTSS Service Coordinators shall not routinely conduct such reviews on a daily basis. This applies to both inpatient and outpatient settings.

DHP reviews the clinical received from Providers or Facilities, makes a determination, and communicates to the Provider/Facility within the required determination timeframes for the type of review performed.
DHP requests Providers/Facilities report any change in admission status to DHP within one (1) business day of the status change.

Scope of Review Information

Information Utilized During Utilization Reviews

Driscoll Health Plan (DHP), when conducting routine prospective, concurrent, or retrospective review:

- Accepts information from any reasonably reliable source that will assist in the certification process including Members, Primary Care Providers (PCP), treating Providers, Consultants involved in care, or other Health Care Professionals and Facilities rendering care;
- Does not routinely request copies of all medical records on all patients reviewed;
- Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission, length of stay or extension of stay, procedure or treatment, frequency or duration of service, or length of anticipated inability to return to work; and compliance with federal regulations specifying information required for utilization review; Documents may include, clinical and diagnostic testing, information regarding diagnoses, relevant medical history, the plan of treatment prescribed by the treating provider and the provider's justification for the plan of treatment (see the DHP Authorization Requirement Portal website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing);
- Does not routinely require Providers or Facilities to numerically code diagnoses to be considered for certification, but may request such codes, if available;
- Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from Member or Provider;
- Protects Member and Provider confidentiality when obtaining or sharing medical information; and
- Requires elective services provided by non-participating providers, also known as "out-of-network" providers, be authorized in advance of the service by the UM Department or STAR Kids LTSS Department. DHP authorizes out-of-network referrals on a limited basis. Services must be medically necessary and not available within the network. DHP may approve services with out-of-network providers in situations where the member may have a long-standing relationship with a provider to ensure continuity of care.

Admission Notification and Clinical Submission

DHP requires admission notification within one (1) business day of admission. Facilities are required to submit clinical documentation supporting medical necessity within two (2) business days of the admission. Supporting documentation includes but is not limited to the physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required (see the DHP Authorization Requirement Portal website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing).

If additional information is required related to a concurrent review or for continued stay, DHP will contact the facility. The due date of additional clinical is within one (1) business day of request. If additional information is required related to a retrospective review, facilities are required to submit requested information within three (3) business days of request.

Insufficient Lack of Information Policy and Procedures

If during the review of a preauthorization referral request for services, DHP determines there is no clinical information provided or the information provided with the request is insufficient, DHP shall contact the Attending Provider, Ordering Provider, or Facility rendering service via USPS letter and fax and/or phone to request needed information. The request will specify the information needed and the date the information is due to DHP. If DHP does not receive the requested information by the due date, this may result in an administrative denial for lack of information or non-certification based on lack of information.

The timeframe specified in that communication must be appropriate to the clinical circumstances of the review (that is, whether the review is prospective, concurrent, retrospective, urgent, non-urgent). Lack of information requests (excluding

STAR/STAR Kids outpatient services with the exception of non-emergent ambulance services), which are prospective or concurrent routine requests, Providers are given one (1) business day to submit additional clinical information. Providers have three (3) business days to submit additional clinical information for retrospective reviews lacking clinical information.

Insufficient Lack of Information

If the preauthorization referral request is for a STAR or STAR Kids Member of any age, for an outpatient service (excluding non-emergent ambulance services) and is lacking information or insufficient information is provided to make a determination, the Insufficient Lack of Information Process may apply based on state regulations.

a. Within three business days from receipt of the prior authorization request, DHP sends the Requesting Provider the *Lack of Information Clinical Request Letter* describing specifically what clinical information or documentation to support medical necessity is lacking and needed in order to make a determination and provides the date when this information is due to DHP (three (3) business days from the date of the request by DHP). The Member and Rendering Provider receive a copy of this letter.
b. DHP forwards the preauthorization referral request to the Peer Clinical Reviewer for review of medical necessity if DHP received no information or insufficient information from the provider. This could result in a medical necessity denial due to lacking or insufficient information.
c. The Peer Clinical Reviewer will make a decision on the preauthorization referral request within two (2) business days from the date the request was forwarded to him/her;
d. It the Peer Clinical review results in a non-certification of requested services, the Requesting and Rendering Provider receive faxed notification regarding peer-to-peer conversation reasonable opportunity. DHP allows for one (1) business day for the provider to request the peer-to-peer conversation (see *Peer-to-Peer Conversation* section of this document listed above for further information related to peer-to-peer reasonable opportunity).
e. DHP enters a determination on the preauthorization referral, one (1) business day from the date of the Peer Clinical Reviewer decision, after completion of the peer-to-peer reasonable opportunity window.
f. For non-certification determinations, the Member will receive a written notification of non-certification letter based on state regulation requirements. Requesting Provider and Rendering Provider or Facility receive a copy of this letter.
g. The Insufficient Lack of Information Process will not exceed 10 business days/14 calendar days from date of receipt of the preauthorization referral request by DHP. DHP will adjust the timeline as necessary, if for example, a holiday closure will result in the preauthorization referral request and review process exceeding the 14-calendar daytime limit, so the preauthorization timeline does not exceed 14 calendar days.

If the Provider responds by providing more information or by communicating that there is no more information available, DHP will treat the case as though there was sufficient information upon which to base a certification decision, under the procedures outlined in this program description.

Per HHSC guidance, if DHP denies the preauthorization referral request for medical necessity due to lack of information, providers may either appeal the decision on the request or submit a new, complete preauthorization referral request.

Notifications and Letters

Notices of Initial Determinations

Certification (Authorization) Decision Notice and Tracking:

The UM Department or Population Health (STAR Kids LTSS) Department will notify the appropriate Provider(s) or Facility of certification determination (authorization) made during the utilization review process via an auto-fax, direct fax, phone, and/or Provider Portal. The notification of certification will include the authorization referral number of the request for certification.

Driscoll Health Plan (DHP) notifies CHIP, STAR, and STAR Kids Members, or persons acting on behalf of the Member, via a mailed letter within one business day of a certification related to a preauthorization referral request. DHP also guides the Member to the DHP website to access this information. DHP advises all Members they may call Customer Service at

1-877-220-6376 for CHIP/STAR, or **1-844-508-4672** (Nueces SA), or **1-844-508-4674** (Hidalgo SA) for STAR Kids for certification determination (authorization) status.

Upon request from the provider or member, the UM or Star Kids LTSS staff member issuing the notification will issue a written notification to the requesting party.

Continued Certification Decision Requirements

For continued hospitalization care or services, the certification (authorization) notification shall include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services via a fax to the Provider(s) and/or Facility.

Notice of Non-Certification Decisions

If the UM Department or Population Health (STAR Kids LTSS) Department is unable to issue a certification decision, staff will refer the case to an available Peer Clinical Reviewer. Only a Peer Clinical Reviewer may issue a non-certification (adverse determination) decision.

Adverse Determination: A determination by utilization review clinical staff that health care services provided or proposed health care services to a Member are not medically necessary or are experimental or investigational.

Written Notice of Non-Certification Decisions and Rationale

Where a Peer Clinical Reviewer issues a non-certification, he/she will assure that the specific principal reason for the non-certification is included in the written notice of non-certification. The Peer Clinical Reviewer also will document in the preauthorization referral the clinical rationale basis for his/her non-certification decision as well as a description of or the source of the screening criteria used.

DHP sends the written notification of non-certification letter to the Member with a copy to the Requesting Provider and Rendering Provider or Facility.

Discharge Planning

Discharge planning refers to all aspects of planning for post-hospital needs and ensuring the continuity of quality medical care in an efficient and cost-effective manner and should begin prior to admission. Discharge planning activities include provisions for and/or referral authorizations to services required in improving and maintaining the patient's health and welfare following discharge.

Driscoll Health Plan (DHP), Providers, and Facilities initiate discharge planning to facilitate the transition of the Member to the next phase of care through coordination with a multi-disciplinary team. DHP recognizes that discharge planning is a process, which requires multidisciplinary involvement to achieve the greatest success. Consequently, DHP seeks input from all Health Care Professionals such as Nurses, Physical Therapists, as well as any other ancillary staff. The DHP UM Case Managers or STAR Kids LTSS Service Coordinators work with the Attending Provider, the Member, the Member's family, and other Health Care Professionals to ensure continuity of care after discharge

The functions of discharge planning include:

a. Identifying discharge planning needs in anticipation of/or early in the hospital admission;
b. Coordinating discharge plans with multi-disciplinary team;
c. Informing and assisting the Primary Care Provider (PCP) in obtaining appropriate clinical information; and
d. Assistance in arranging implementation of post discharge service.

Providers should discuss anticipated discharge needs with the UM Department or STAR Kids LTSS Department prior to admission, or as early as possible in the admission. All admissions require authorization, with the exception of routine deliveries.

Providers and/or Facilities should call the DHP UM Department or STAR Kids LTSS Department to facilitate discharge planning for Members in the hospital. The UM Department Case Manager or LTSS Service Coordinator may help in:

- Arranging home health services and durable medical equipment (DME);
- Admissions/transfers to other facilities;
- Coordinating medical transportation;
- Questions on benefits or coverage;
- Authorization and arrangement of transfer of out-of-area patients;
- Information and referral to community resources;
- Referrals to Community-Based Services as appropriate for STAR Kids Members; and
- For STAR Kids MDCP Members assess for any change in condition and arranges for LTSS services as deemed medically necessary.

Providers and/or Facilities agree to work collaboratively with DHP's UM Department or STAR Kids LTSS Department as appropriate to communicate the members' discharge plans. Providers and/or Facilities should provide discharge plans as well as a copy of the discharge summary to DHP within two (2) business days of discharge.

Definition of Admissions

Elective Admission: Elective, or pre-planned, admissions generally include elective surgeries and admissions for elective treatment that requires an acute care setting for management.

Observation Admission: Observation admission required post-operatively for medically necessity or known risk factors or medical conditions requiring frequent monitoring by the nursing staff. Authorization for observation admissions is 48 hours.

In cases where a Member requires an observation admission beyond the initial 48-hour observation period, the Admitting Provider must contact the Driscoll Health Plan (DHP) UM Department for authorization for inpatient admission. If the decision to keep the patient beyond the 48-hour observation period occurs after 5 pm, the Attending Provider should contact DHP the next business day. There is a UM Department Case Manager on call available after hours if the Provider or Facility wishes to discuss the case further. Providers or Facilities can reach the Case Manager on call after 5 p.m., by calling the toll-free preauthorization number listed at the bottom of this page. The phone recording prompts direct the caller to the Case Manager/Registered Nurse on call.

Direct Urgent Admissions: Admissions that take place upon direct referral from a Provider's office or Provider directs Member to go to the hospital. The facility is required to notify DHP within 24 hours or next business day of the admission.

Emergency Admissions: An emergency admission usually occurs directly from a hospital emergency facility following evaluation and stabilization of a medical condition of recent onset and severity. These admissions may occur after regular business hours. The facility should contact the DHP's UM Department within 24 hours or next business day for authorization.

Vision Services

As of August 1, 2015, Envolve Vision of Texas (formerly OptiCare Managed Vision/AECC Total Vision Health of Texas, Inc.) administers both routine vision and medical eye care services for Driscoll Health Plan (DHP). These services are administered and payable directly by Envolve Vision of Texas.

IMPORTANT: Providers must submit claims for routine and medical eye care services performed on or after August 1, 2015, to Envolve Vision of Texas. For your convenience, plan specifics outlining the benefit information for Driscoll are

located through Envolve Vision of Texas 24/7 Provider Portal, Eye Health Manager at:
https://visionbenefits.envolvehealth.com/logon.aspx

Extremely Low Birth Weight / Extreme Prematurity and Severe and/or Complex Conditions Newborn Guidelines for the Nueces Service Area

Newborns born at <29 weeks' gestation, who weigh 1000 grams or less at birth, who have congenital conditions, or who have severe and/or complex condition are in the highest risk group and have the most specialized needs. Facilities must notify Driscoll Health Plan (DHP) UM Department within one (1) business day of the birth of an extremely low birth weight and/or extremely premature newborn, or a newborn with an obvious severe and/or complex condition.

Regional Facilities with the greatest depth of neonatal capabilities care for these newborns to provide for optimal care and outcome. The optimal time of transfer should be within the first 12 hours after birth or once stabilized but no more than three (3) days after birth. DHP may forward the following for Peer Clinical Review for exception of DHP policy:

- Stable newborns <1000 grams but equal to or >29 weeks with no co-morbid conditions such as Respiratory Distress Syndrome (RDS) requiring ventilation;
- Continuous infusions, such as vasoactive and sedative medications; or
- Severe and/or complex illnesses (congenital birth defects, deformities, grade 3 or 4 Intra-Ventricular Hemorrhage (IVH)).

CRITERIA:
A regional facility capable of caring for these newborns shall have the following capabilities:

- Ability to provide comprehensive care for extremely low birth weight infants or premature newborns with the most complex medical problem;
- Advanced respiratory support such as high-frequency ventilation and inhaled nitric oxide for as long as required;
- Continuously available, 24 hours a day, seven (7) days a week, board-certified or board eligible Neonatologists;
- A comprehensive range of Pediatric Medical Subspecialists and Pediatric Surgical Subspecialists will be immediately available to arrive on-site for face-to-face consultation and care for an urgent request within one (1) hour. These Subspecialists include but are not limited to:
    - Pediatric Surgical Subspecialist experienced in major surgeries such as ligation of patent ductus arteriosus and repair abdominal wall defects, necrotizing enterocolitis with bowel perforation, tracheoesophageal fistula and/or esophageal atresia, and myelomeningocele;
    - Neurologist;
    - Cardiologists;
    - Anesthesiologists;
    - Endocrinologists;
    - Neurosurgeons;
    - Urologists;
    - Orthopedists; and
    - Cardiothoracic surgeons
- Pediatric Radiologists who can perform advanced imaging with interpretation on urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography;
- Perinatal Pathologists and related services available;
- Access to Ophthalmologists who are experienced in the diagnosis and treatment of retinopathy of prematurity and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity;
- Respiratory Therapist with neonatal experience continuously on-site;
- A certified Lactation Consultant available for consultations;
- Perinatal education: A Registered Nurse with experience in neonatal care shall provide supervision and coordination of staff education; and
- Facilitate and provided Neonatal transport. Oscillatory ventilation is available when indicated for transport.

Until newborns are stable enough to transfer, there will be daily DHP Peer Clinical reviews.

Failure to transfer qualifying newborns after stabilization will result in authorization denial for subsequent days. DHP will not pay unauthorized days unless overturned upon appeal.

Therapy Guidelines

Providers can find guidelines for approval of therapy services (i.e., Physical Therapy, Occupational Therapy, and Speech Therapy) on the Driscoll Health Plan (DHP) website at **http://www.Driscollhealthplan.com/pdf/TherapyGuidelines.pdf**.

Chiropractic Services

Chiropractic services are available for Members. Requests for Chiropractic services do not require a Provider referral but do require a preauthorization. The services are limited to 12 visits for spinal subluxation only. Additional visits will require preauthorization. For preauthorization, contact the Driscoll Health Plan (DHP) UM Department via telephone or facsimile numbers listed at the bottom of this page or via the Provider Portal on the internet.

Transplant Services

Providers who are caring for Members who may be under consideration for transplant services must notify Driscoll Health Plan (DHP). DHP Case Management will become involved with this Member and follow them through the pre-transplant and final transplantation process. DHP requires preauthorization for admission to any transplant facility. DHP will evaluate any nationally recognized facility for approval based on the medical necessity of services for the Member. For prior approval and notification of potential transplantation, contact the DHP UM Department at the phone number listed at the bottom of this page.

SECTION VII

Pharmacy

Subcontractor for Pharmacy Benefit

DHP is contracted with Navitus Health Solutions, LLC, as the Pharmacy Benefits Manager that will provide prescription drugs to our membership. For questions regarding pharmacy benefits, contact DHP at the toll free numbers at the bottom of this page. Navitus provides contracts with Pharmacies throughout the service delivery areas. Members have a right to obtain medication from any Network pharmacy.

Pharmacy Provider Responsibilities

The following information is provided to DHP providers as informational.

The Pharmacy Providers are required to adhere to the following responsibilities:

- The Pharmacy must adhere to the DHP Formulary and Preferred Drug List (PDL).
- Prescription drugs and Durable Medical Equipment (DME), as appropriate, must be coordinated with the prescriber physician.
- The Pharmacy must ensure that DHP Members receive all medications for which they are eligible.
- There must be coordination of benefits, if the Member also receives Medicare Part D services or other insurance benefits, as applicable.

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 with a 90-day copay.

STAR Member Prescriptions

STAR members may have an unlimited number of prescriptions each month. This includes adult STAR members as well as children STAR members.

STAR Kids Member Prescriptions

STAR Kids members may have an unlimited number of prescriptions each month.

Verification of Eligibility by Pharmacies

Pharmacies may verify eligibility electronically via NCPDP E1 Transaction.

Claims Payment to Pharmacies

Pharmacies will submit claims to Navitus Health Solutions. Medications that require prior authorizations will undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that

point, the pharmacy should notify the prescriber and the process for requesting a prior authorization will need to be followed.

Pharmacies will be paid within 18 days of the electronic clean claim submission and 21 days for clean claim payment for non-electronic pharmacy claims submissions to Navitus Health Solutions. These payments can be paper check, or electronic fund transfer.

Billing of Services by the Pharmacy

Navitus Health Solutions provides the following information to Pharmacies regarding billing for compound medications:

Compounded Prescriptions

A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices.

For Navitus to cover a compound, all active ingredients must be covered on the Member's formulary. In general, drugs used in a compound follow the Member's formulary as if each drug components were being dispensed individually. The Payer must include Compound Drugs as a covered benefit for the Member for Navitus to allow reimbursement.

Any compounded prescription ingredient that is not approved by the FDA (e.g. Estriol) is considered a non-covered product and will not be eligible for reimbursement.

Please contact DHP at the phone number at the bottom of this page for questions regarding compound prescriptions.

Processing Compound Prescriptions

Navitus uses a combination of the claims, compound and DUR segment to fully adjudicate a compound prescription. Use the Compound Code of 02 (NCPDP field 406- D6 located in Claim Segment on payer sheet) when submitting compound claims

The claim must include an NDC for each ingredient within the Compound Prescription with a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC located in Compound Segment).

The claim must include a qualifier of "02" (NDC) to be populated in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's).

If an NDC for a non-covered drug is submitted, the claim will be denied.

If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field)

This will allow the claim to pay and the pharmacy will be reimbursed for all drugs except the rejected medication with Clarification Code of 8.

Compounds with a cost exceeding $200 must receive an approved prior authorization from Navitus for coverage to be considered. Forms are available at **www.navitus.com**.

If a compound includes a drug that requires prior authorization under the member's plan, the prior authorization must be approved before the compound is submitted.

Compound Claims forms are available at **www.navitus.com**

Submit the minutes spent compounding the prescription for reimbursement. The minutes listed are to be populated within NCPDP D.0 Field 474-8E (level of effort - DUR segment).

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 prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

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

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

To be reimbursed for 72-hour emergency prescription supplies:

1. Contact Navitus at **1-877-908-6023** for procedures on 72-hour emergency prescription supplies.
2. If the prescription is a medical versus pharmacy benefit, submit claims to DHP. The Driscoll Health Plan Payer ID is Change Healthcare **Payer ID # 74284**.

DHP accepts claims via 837 electronic claims submission. For the latest Companion Guides, visit the DHP website at **www.driscollhealthplan.com**

Prescription Drug Monitoring Program

Driscoll Health Plan recommends providers follow Texas State law requiring pharmacists and prescribers to check the Prescription Monitoring Program (PMP) patient history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. According to this mandate, prescribers must document in the patient's medical record that they checked the PMP.

Paper Claims Submission to DHP

Paper claim forms are mailed to DHP by Durable Medical Equipment pharmacies that are directly contracted with DHP. The address for these submitted claims is:

Driscoll Health Plan
ATTN: CLAIMS P.O. Box 3668
Corpus Christi, TX 78463-3668

Call Driscoll Health Plan's Prescription Benefit Manager Navitus Customer Care at 1-877-908-6023 for more information about the 72-hour emergency prescription supply policy, or other claim submission information. The majority of claims for Navitus occur at point of sale by their contracted pharmacies. Paper claims may be sent to:

Navitus Health Solutions Operations Division-Claims
1025 W. Navitus Drive
Appleton, WI. 54913
Or fax to 855-668-8550

Claim form can be found at **www.navitus.com>members>filing a claim**.

How to Find a List of Covered Drugs / How to Find a List of Preferred Drugs

A list of covered drugs is available via the Driscoll Health Plan website at **www.driscollhealthplan.com**. This formulary list is required to be used by DHP. This same website also has the Preferred Drug List (PDL). For providers, this list of covered drugs is available at the Navitus Health Solutions website, through the Provider Portal at **www.navitus.com**. Providers may also access the formularies for CHIP and Medicaid, and the Medicaid preferred list at **www.texasvendordrug.com**. Providers may also subscribe to the HHSC free subscription services for accessing such information through the internet or hand-held devices. This information is also available at **http://www.txvendordrug.com/**.

Requesting a Prior Authorization (PA) for a Drug That Requires PA

To request a prior authorization for a drug that requires a PA, information that is needed to be provided is located at the Navitus Health Solutions, LLC website at **https://prescribers.navitus.com/**.

To access the necessary form, all the provider needs is his/her NPI number. Completed forms can be faxed 24 hours a day, seven days a week, to Navitus at **855-668-8553**. Prescribers can also call Navitus Customer Care at **1-877-908-6023**, prescriber option and speak with the Prior Authorization department between 8 a.m. and 5 p.m. Central Time to submit a PA request over the phone. After hours, providers will have the option to leave 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 the phone request.

SECTION VIII

Billing and Claims

Billing and Claims Requirement

Driscoll Health Plan requires providers to bill and code claims in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM) guidelines and comply with all NCCI billing requirements.

What is a Claim?

A claim is a request for payment. DHP uses the standard CMS-1500 (professional) and CMS-1450 (UB04 institutional) paper claim forms as required by provider type OR the ANSI-837 I or P format for electronic claims submissions for all claim type submissions. For the latest Companion Guides, visit the DHP website at **www.driscollhealthplan.com**.

What is a Clean Claim?

A clean claim is defined as a claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for DHP to adjudicate and accurately report the claims. A clean claim must meet all requirements for accurate and complete data as defined in the 837 Companion Guide located on the DHP website at **www.driscollhealthplan.com**.

Once a clean claim is received DHP is required, within the 30-day claim payment period, to:

- Pay the claim in accordance with the provider contract, or
- Deny the entire claim, or part of the claim, and notify you why the claim or part of the claim was not paid.

Electronic Claims Submission: ANSI-837

DHP accepts claims via 837 electronic claims submission. For the latest Companion Guides, visit the DHP website at **www.driscollhealthplan.com**.

The Driscoll Health Plan Payer ID is Change Healthcare **Payer ID # 74284.**

Methods of Electronic Submission of Claims to DHP

Claims may be submitted to DHP through DHP's Provider Claims Portal, TMHP's Claims Portal or through a provider's clearinghouse to the Driscoll Health Plan Payer ID which is Change Healthcare **Payer ID # 74284**.

DHP's Claims Portal accepts professional and institutional claims: Both professional (HCFA) and institutional (UB) claims can be submitted via a batch file import. Only professional (HCFA) claims can be direct data entered (DDE).

Paper Claims Submission to DHP

Paper claim forms are mailed to:

Driscoll Health Plan
Attention: Claims Department
P. O. Box 3668
Corpus Christi, TX 78463-3668

Submitting Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

Claims returned requesting additional information or documentation should not be submitted as corrected claims. While these claims have been processed, additional information is needed to finalize payment.

When submitting a corrected claim either electronically (via your clearinghouse, or the TMHP or DHP Portals), or submitting by paper, use the Bill and Frequency Type codes listed below. If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

- Corrected Claim
  - CMS Form
    - Electronic Claim
      - Frequency Type – 7
    - Paper Claim
      - Resubmission Code (Field 22) – 7
  - UB04 Form
    - Electronic Claim
      - Third digit of Bill Type – 7
    - Paper Claim
      - Third digit of Bill Type – 7
- Voided Claim
  - CMS Form
    - Electronic Claim
      - Frequency Type – 8
    - Paper Claim
      - Resubmission Code (Field 22) – 8
  - UB04 Form
    - Electronic Claim
      - Third digit of Bill Type – 8
    - Paper Claim
      - Third digit of Bill Type - 8

Failure to mark your claim appropriately may result in rejection as a duplicate.

***Note**: DHP does not consider a corrected claim to be an appeal. Providers requesting reconsideration of a previously processed claim (whether paid or denied) must file the request using the DHP Provider Appeal process.*

Corrected claims must be submitted within 120 days from the date of the provider's EOP.
If providers have questions regarding submitting corrected claims through DHP's Claims Portal, they are to call **877-667-1512**. If providers have questions regarding submitting corrected claims through the THMP Claims Portal, they are to call **888-863-3638**.

If you have questions, feel free to contact Provider Services at **1-855-425-3247**.

Timeliness of Billing

Claims and/or encounters must be submitted as follows:

Type of Claim	Timely Billing Parameter
Professional Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format.	95 days from the **DATE OF SERVICE**

Ancillary Services Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format.	95 days from the **DATE OF SERVICE**
Ancillary Services Claims for services that are billed on a monthly basis submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format (e.g. home health or rehabilitation therapy).	95 days from the **LAST DAY OF THE MONTH** for which services are being billed
Outpatient Hospital Services billed on CMS-1450 (UB04 institutional claim from) or using the institutional ANSI-837 electronic claim format.	95 days from the **DATE OF SERVICE**
Inpatient Hospital Services claims billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format	95 days from the **DATE OF DISCHARGE**
LTSS (including nontraditional LTSS providers)	95 days from **DATE OF SERVICE**

Claims not submitted in accordance with the above noted deadlines will be denied for timely filing.

Please do not submit duplicate claims, from original submission date, prior to 30 days from the date of original submission. You may check claims status through the Provider Portal.

Timeliness of Payment

DHP will pay all clean claims submitted in the acceptable formats as previously detailed within 30 days from the date of receipt or the date that the claim is deemed "clean". Should DHP fail to pay the provider within the thirty days, the provider will be reimbursed the interest on the unpaid claim at a rate of 1.5% per month (18% annum) for every month the claim remains unpaid.

Claims Status and Follow-Up

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

- Obtain claim status via the DHP Provider Web portal.
- Fax Claims Status Request to: **1-361-808-2079** and DHP will respond in two (2) Business Days.
- Providers may call **1-855-425-3247** or **1-877-324-3627** for Nueces and obtain status telephonically for up to eight (8) claims daily (DHP policy can only obtain status telephonically for up to eight (8) claims).
- Providers are able to check claims statuses through the IVR Call System for dates of service 2/1/19 or later.

***Note**: Web Portal agreements are available on the DHP website Providers Page at: **www.driscollhealthplan.com**.*

Filing an Appeal for Non-Payment of a Claim

Provider & Administrative Claims Appeals are processed by the Claims Department:

Driscoll Health Plan
ATTN: CLAIMS APPEAL DEPARTMENT
P.O. Box 3668
Corpus Christi, TX 78463-3668
Fax Number 361-808-2776

Administrative denials for non-timely filing of claims or claim appeals, or failure to obtain authorization for services rendered, will not be overturned. Administrative reconsideration is appropriate only when DHP has

made a processing error, or new information is provided to support reconsideration. Claim appeals may be submitted using the DHP Administrative Claim Denial/Payment Reconsideration Form located in the Appendix.

For assistance with claim appeal submission or status, please contact the DHP Provider Services department at **1-877-324-3627** (Nueces SA) or **1-855-425-3247** (Hidalgo SA).

Reminder about NCCI Guidelines and Currently Published Procedure Code Limitations

This is a reminder that the Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Bulletin are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI **https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-%20Coding-Edits.html** web page for correct coding guidelines and specific applicable code combinations. In instances when Texas Medicaid medical policy is more restrictive than NCCI medically unlikely edits (MUE) guidance, Texas Medicaid medical policy prevails.

Coding Requirements: ICD10 and CPT/HCPCS Codes

CPT Category II Codes: Provider use of CAT II codes significantly reduces provider administrative burdens associated with Chart Requests for Medical Record Reviews. CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement which includes HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and **may reduce the need for retrospective medical record review.** Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I Codes. However, as noted above, **submission of these codes can minimize the administrative burden on providers** and health plans by greatly decreasing the need for chart requests to facilitate hybrid medical record reviews. DHP requests providers submit appropriate Category II Codes with all claims encounters.

Dental Claims: DHP does not process dental claims. Dental services are provided through a Dental Management Organization (DMO). Providers should contact the State's DMO by calling **1-866-561-5891** for questions concerning benefits and billing.

Emergency Institutional Claims: DHP requires the use of ICD10 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB04 Revenue Code, and either ICD10 or CPT surgical procedure codes. This includes NDC numbers when medications are administered.

Emergency Professional Services Claims: DHP requires the use of ICD10 diagnosis codes and CPT or HCPCS procedure codes.

Inpatient Institutional Claims: DHP requires the use of ICD10 diagnosis codes and either, ICD10 or CPT surgical procedure codes. Line-item charges must be coded with UB04 Revenue Codes.

Outpatient Institutional Claims: DHP requires the use of ICD10 diagnosis codes, HCPCS codes for applicable line-item charges and the corresponding UB04 Revenue Code, and either ICD10 or CPT surgical procedure codes. This includes NDC numbers when medications are administered.

Prescription Drug Claims: DHP does not process prescription drug claims. Prescription drug services are provided for STAR, STAR Kids, and CHIP Members through our subcontractor, Navitus Health Solutions. Inquiries regarding services should be directed to:

CHIP:	**1-877-451-5598**
STAR and STAR Kids (Nueces):	**1-877-220-6376**
STAR and STAR Kids (Hidalgo):	**1-855-425-3247**

Professional Medical Claims: DHP requires the use of ICD10 diagnosis codes and CPT or HCPCS procedure codes. This includes NDC numbers when medications are administered within the provider office.

Driscoll Health Plan Fee Schedules

DHP contracted providers may view the Texas Medicaid Fee Schedules quoted in their contacts at:
http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx

Contracted Hospitals may view their Standard Dollar Amounts (SDA) or Tefra rates at:
http://www.hhsc.state.tx.us/rad/hospital-svcs/inpatient.shtml
http://www.tmhp.com/Pages/Topics/hospital_reimbursement.aspx
Hospitals are reimbursed the lesser of billed charges or APR-DRG / Per Diem billed.

Fee schedules for MDCP may be found at the following link:
http://www.hhsc.state.tx.us/Rad/long-term-svcs/mdcp/index.shtml

Fee schedules for other LTSS, including non-capitated LTSS, may be found at the following link:
http://www.hhsc.state.tx.us/Rad/long-term-svcs/index.shtml

DHP contracted RHC's and FQHC's are required by contract to provide DHP their encounter rates upon contracting and any subsequent updates will be loaded by DHP within 30 days of receipt of a new encounter rate letter being provided to DHP by the provider as indicated in the Provider contract.

For additional information or reimbursement rates the provider may contact DHP Provider Services or their Provider Relations Representative assistance.

E&M Office Visits Billing Requirements

DHP follows standard E&M coding guidelines as promulgated by the Centers for Medicare and Medicaid Services (CMS).

E&M Consult Billing Requirements

DHP follows standard coding and billing requirements for consults, (CPT codes 99241-99275).

Billing for Sports Physical Reimbursements - Value Added Service

- One physical per calendar year
  - STAR: Ages 4 – 19
  - STAR Kids: Ages 4 – 21
  - CHIP: Ages 4 - 18
- For prompt claim payment, please use the following codes:
  - Diagnosis Code – Z02.5
  - CPT Codes – 99211 thru 99214 as appropriate with Modifier SC

Emergency Services Claims

If emergency care is needed, it should be provided immediately in accordance with the procedures described in "IV-Emergency Services" in this manual. Services provided in an emergency situation will be reimbursed in accordance with the hospital's or provider's agreement with DHP. Non-participating providers and hospitals that provide emergency care to Medicaid Members will be paid according to the current Texas Administrative Code ("TAC") on Managed Care Organization Requirements Concerning Out-of-Network Providers.

Emergency services rendered in a hospital emergency room must include on the claims, the most appropriate E/M procedure code on the claim detail line next to the emergency department revenue code. The procedure code will determine whether the service is considered to be urgent or emergency. Non-emergent and non-urgent evaluation services will be reduced by 40%, per Texas Medicaid policy for STAR & STAR Kids /Medicaid Members. Providers must submit the revenue code and procedure code combination that accurately reflects the services that were provided. All claims are subject to retrospective review.

As of the publish date of this Manual, the statute provides: 1) out of network, in area providers are reimbursed the Medicaid Fee for Service rate in effect on the date of service less 5% and any other state mandated reductions; 2) out of network, out of area providers are reimbursed 100% of the Medicaid Fee for Service rate less any state mandated reductions. Please refer to the TAC for the most current payment rules.

At a minimum, the participating MCO must provide a benefit package to Members that includes Fee-for-Services (FFS) acute care and LTSS services currently covered under the Texas Medicaid program. MDCP services are covered for individuals who qualify for and are approved to receive MDCP. See Texas Provider Procedure Manual (TMPPM) for listings of limitations and exclusions.

Ambulance Claims

Emergency ambulance transportation is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes.

- Providers must submit claims for emergency ambulance transport with the ET modifier on each procedure code submitted on the claim.
- Place of service 41 and 42 are accepted by Texas Medicaid for ambulance claim submission; the two-digit origin and destination codes are also required for claim submission.
- Ambulance transportation claims may be submitted electronically as an 837 professional claim or by paper on the CMS-1500 form.

Claims for Clients with Retroactive Eligibility

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment. Retroactive eligibility does not constitute an exception to the federal filing deadline.

Claims for Services Rendered in a Nursing Facility or Intermediate Care Facility

DHP is not responsible for providing payments to a Nursing Facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other related conditions. Payments for these services are provided through the Fee-For-Service Medicaid program and claims should be submitted to TMHP. DHP services are not provided through the facility as part of the facility's Day Rate.

STAR Kids Claims for Custom DME or Minor Home Modifications When a Member Changes MCO

In cases where an individual changes health plans and a prior authorization is open for custom DME or an Augmentative Device, the following describes the payment responsibility:

- **Member moves between STAR Kids MCO's:** The former MCO who authorized the service is responsible for payment.
- **Member moves from FFS to a STAR Kids MCO:** The MCO is responsible for payment.

Claims for STAR Kids LTSS Services

See **Appendix** for the following:

- Who is responsible for payment of each specific service for DHP STAR Kids members?
- Who is responsible for payment of each specific service for Driscoll's Dual-eligible STAR Kids members?
- Who is responsible for payment for additional LTSS services available to STAR Kids members?

Use of Modifier 25

DHP will accept modifier 25 codes when submitted in accordance with the following requirements:

Modifier 25 is used on a valid CPT or HCPCS procedure code to indicate that the identified service was provided as a distinctly separate service from other similar services furnished on the same date of service.

EXAMPLE: Providing an age-appropriate health screening on the same day as a sick visit.

- **Sick Visit** - Select the appropriate E&M Office Visit Code
- **Preventive Screen** - Select the age-appropriate preventive E&M Code and affix the 25 modifier.

Providers may use the modifier 25 when billing an E&M code with another significant procedure on the same day. The modifier 25 should be affixed to the E&M code only. The medical record should clearly support the significance and distinctiveness of the associated procedure.
The modifier 25 may also be used to bill a preventive health screen, or Texas Health Steps exam, performed on the same day as a sick visit. The modifier 25 should be affixed to the preventive screen code.

The DHP Waste, Abuse, and Fraud (WAF) special investigative unit monitors modifier 25 billings. Occasional chart audits are performed to comply with our WAF program requirements.

Billing for Assistant Surgeon Services

DHP provides coverage for Assistant Surgeon services authorized in accordance with DHP policies for certain CPT codes. All Assistant Surgeon services require preauthorization. Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate. Two assistant surgeons may be allowed when prior authorization for liver transplant surgery using the appropriate assistant surgery modifier with procedure codes 47135 or 47136. Please contact DHP Health Services or STAR Kids Support Services Department for authorization.

Locum Tenens

A locum tenens arrangement is one in which a substitute physician assumes the practice of a billing physician who is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the armed forces. The locum tenens arrangement may be extended for a continuous period of longer than 60 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the armed forces. Locum tenens arrangements must be in writing. The substitute physician is not required to enroll in Texas Medicaid. The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33.

When a physician bills for a substitute physician, modifier Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q6 modifier is used to indicate a locum tenens arrangement. When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J. Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

Billing for Capitated Services

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

For a complete list of capitated services along with applicable carve outs and services that are allowable, please refer to your provider contract, or contact Provider Services at the number listed below.

Billing for Immunization and Vaccine Services

Childhood Immunizations:

Primary Care Provider (PCP)'s who furnish immunization services for children are required to enroll with the Texas Vaccine for Children (VFC) program. The program provides vaccines for childhood immunization. DHP does not reimburse for vaccines, but will reimburse Primary Care Provider (PCP)'s for the administration of vaccine.

Adult Immunizations:

DHP covers adult immunization services. Providers may bill for both the vaccine (using the appropriate HCPCS code) and for vaccine administration.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

DHP 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 bedpans, and other supplies and equipment. For children (birth through age 20), DHP 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.

All In-Network DHP Pharmacy Providers, who are also In-Network Providers with the Vendor Drug Program (VDP) and Navitus Health Solutions (DHP's PBM), are required to submit claims for Diabetic Supplies & Limited Home Health Supplies (LHHS) to Navitus for reimbursement and not to DHP. The diabetic and limited home health supplies that can be dispensed to DHP members and billed to Navitus for reimbursement include the following:

- Diabetic insulin syringe with needle 1 cc or less
- Diabetic insulin needles
- Diabetic blood glucose test strips

- Diabetic lancets
- Spring-powered device for lancet
- Home glucose disposable monitor (includes test strips)
- Talking diabetic blood glucose monitors
- Aerosol holding chamber
- Oral electrolytes
- Hypertonic saline solution

Claims are subject to post-payment desk reviews to ensure claims from durable medical equipment (DME) providers and pharmacies do not result in either a client who exceeds the maximum quantity or a duplicate payment from DHP for the same client.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must enroll as Texas Medicaid DME providers. Important: The Center for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.

Call for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20) you may call the following numbers:

CHIP/STAR (Nueces)	CHIP/STAR (Hidalgo)	STAR Kids (Nueces)	STAR Kids (Hidalgo)
1-877-324-3627	1-855-425-3247	1-844-508-4672	1-844-508-4674

DME Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8441. See the applicable fee schedule on the TMHP website at **www.tmhp.com**.Providers may be reimbursed for DME either by the lesser of the provider's billed charges or the published fee determined by HHSC or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

- The MSRP or AWP, whichever is applicable.
- The provider's documented invoice cost.
- Manually priced items are reimbursed as follows as is appropriate: MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable.

Billing for Texas Health Steps or Well Child Visit Services

Texas Health Steps (THSteps) Providers need to ensure billing requirements for THSteps visits are met including required Modifiers for Performing Providers, Exception to Periodicity, FQHC & RHC requirements. Requirements can be found on the Texas Health Steps Quick Reference Guide at:
http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/Texas Health StepsQRG/Texas Health Steps_QRG.pdf.

Additionally, THSteps providers must send all THSteps newborn screen to the Texas Department of State Health Services (DSHS), Bureau of Laboratories or a DSHS certified lab. THSteps providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow up. Billing for services outside of the Periodicity schedule listed in *"STAR & STAR Kids, Section D, Texas Health Steps Program"* or *"CHIP, Section C, Well Child Visits"* in this manual will only be paid for exceptions listed in that section. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

Billing for Deliveries and Newborn Services

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

Claim forms that reflect combined charges for both a mother and a newborn will be rejected or will be subject to denial.

For information regarding billing for deliveries and newborn care for the CHIP Perinate and CHIP Perinate Newborn please see the Section for CHIP in this manual.

Billing for Outpatient Surgery Services

Outpatient Surgeries require preauthorization. To ensure payment for surgery, include the authorization number on your submitted claim. An authorization may be obtained by either submitting a request via our website at **www.driscollhealthplan.com** or contacting the CHIP/STAR Members or Support Services Department for STAR Kids Members at the phone number at the bottom of this page.

Physician Claims: Submit the claim on the standard CMS-1500 or using the acceptable ANSI-837 professional electronic formats. The applicable CPT-coded surgical procedure code(s) must be identified.

Facility Claims: Claims from hospitals, ambulatory surgery centers or other facilities where outpatient surgery may be performed, must be submitted on the CMS-1450 (UB04) form of using the acceptable ANSI-837 institutional electronic format, with the applicable ICD9, ICD10 surgical procedures code(s), date of the surgery, itemized charges, and associated CPT/HCPCS procedure codes.

Billing for Hospital Observation Services

Facilities are eligible to receive reimbursement for authorized Observation Admissions. DHP considers an observation claim to be an outpatient claim. In the itemized charges section of the claim form a line showing the UB Revenue Code should be shown with a number of hours of observation. Observation cannot exceed 48 hours. If the patient requires observation for longer than 48 hours, the facility must convert the claim to an inpatient and bill the services as an inpatient admission. In cases where an observation stay is converted to inpatient, the facility should notify the Health Services Department at the phone number below. Labor and Delivery Observation Stays do not require authorization.

Coordination of Benefits (COB) Requirements

DHP utilizes a third-party vendor to verify COB status on all DHP Plan Members. Verified information obtained through this process will take precedent on all claim processing. For more information on other coverage please contact Member Services. For further information on COB claims, please contact your Provider Relationship Representative. DHP is the payer of last resort. Providers must bill all other carriers and receive payment or denial prior to billing DHP.

Inpatient:

- **CHIP, STAR, and STAR Kids Members**: If DHP is the secondary payer for inpatient services, authorizations is required. No authorization is required for observation services if DHP is secondary payer.

Outpatient:

- CHIP, STAR, and STAR Kids Members: Some outpatient services/procedure codes may require prior authorization regardless of DHP as secondary payer. Providers should verify authorization requirements on the DHP Prior Authorization Portal at https://driscollhealthplan.com/priorauthcheck. In cases where DHP is secondary payer and no prior authorization is required, as based on directive within the DHP Prior Authorization Portal, providers should verify the services are a covered benefit by the primary payer. If the services are known to be a non-covered benefit by the primary payer, prior authorization is required by DHP and proof of non-coverage of benefit must accompany the claim submission.
- STAR Kids Members/LTSS Support Services: If DHP is the secondary payer for outpatient services, provider must contact Service Coordination for Coordination of Benefit.

Other Payer Makes Payment: In cases where the other payer makes payment, the CMS-1500, CMS-1450, or applicable ANSI-837 electronic format claim must reflect the other payer information and the amount of the payment received.

Other Payer Denies Payment: In cases where the other payer denies payment, or applies their payment to the Member's deductible, a copy of the applicable denial letter or Explanation of Payment (EOP) must be attached with the claim that is submitted to DHP.

ALL **COB** Claims should be filed electronically or mailed to:

Driscoll Health Plan
Attention: Claims/COB
P.O. Box 3668
Corpus Christi, TX 78463-3668

Billing Members

Balance billing is billing the Member for the difference between what a provider charges and what DHP or any other insurance company has already paid.

Providers are not allowed to "balance bill" DHP Members except as noted below. All covered services are included within the payment made by DHP and the residual balance of covered charges must be written off as a contractual allowance.

Providers are prohibited from billing or collecting any amount from Medicaid/STAR or STAR Kids Member for health care services, unless the provider has advised the Member prior to rendering the service, that the service is a non-covered benefit, or a copay is instituted for Medicaid/STAR members.

For a non-covered benefit, the Member must sign an Advance Beneficiary Notice that documents that the Member was made aware of the responsibility to pay for the service. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service, unless a co-pay has been established by HHSC.

The following table illustrates circumstances concerning billing Members.

Member Billing Situations

SERVICE	PLAN PAYS NOTHING	PLAN PAYS CONTRACTED RATE	PLAN PAYS USUAL & CUSTOMARY	PROVIDER CAN BILL MEMBER if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services	PROVIDER CANNOT BALANCE BILL MEMBER
IN NETWORK					
Authorized		✓			✓
Not Authorized	✓				✓
OUT OF NETWORK					

Authorized			✓		✓
Not Authorized	✓			✓	
EMERGENCY CARE					
Authorized		✓			✓
Not Authorized			✓		✓
LTSS SERVICES					
Authorized		✓			✓
Not Authorized	✓				✓
NON-COVERED SERVICES					
Non-Covered Services	✓			✓ *(See "S"STAR – B – STAR and STAR Kids/Medicaid Covered Services" or "CHIP – B – Covered Services" in this manual)*	

Co-Pay Amounts for CHIP Members: Providers may collect co-pay amounts from CHIP Members as outlined below or on the Member's CHIP identification card. There are no co-pays for CHIP Perinate Newborn and CHIP Perinate Mother.

Co-Pay Amounts for STAR and STAR Kids/Medicaid: There are currently no co-payments for STAR and STAR Kids/Medicaid Members at the publication of this Manual. Co-payments may be instituted by HHSC.

Collecting from or Billing CHIP Members for Co-pay Amounts

Some CHIP Members have co-pay amounts for certain services. The Members' DHP identification card will indicate the co-pay amounts for these specific services. Only valid co- pay amounts can be collected from CHIP Members.
For a list of when a co-pay may apply, refer to *CHIP, Section B*, of this Provider Manual.

Billing Members for Non-Covered Services

Providers may not bill Members for non-covered services UNLESS the provider has obtained a signed Member Acknowledgement Statement or a Private Pay Form (see **Appendix**) from the Member or guarantor prior to furnishing the non-covered service. These forms must be maintained in the provider's records and made available to DHP, HHSC, or agents of HHSC upon request.

- **Member Acknowledgement Statement Form**
  The provider obtains and keeps a written Member Acknowledgement Statement, signed by the Member, when a Member agrees to have services provided that are not a covered benefit for STAR/Medicaid or CHIP. By signing this form, the Member agrees to have the services rendered, and agrees to personally pay for the services (see **Appendix** for a copy of this form).

- **Private Pay Form Agreement**
  The provider obtains and keeps a written Private Pay Form Agreement, signed by the Member, when the Member agrees to have services provided as a private paying patient. By signing this form, the Member agrees to pay for all services, and the provider will not submit a claim to DHP (see **Appendix** for a copy of this form).

Providers Required to Report Credit Balances

Providers are required to report credit balances on accounts of DHP Members within 60 days of the credit balance occurring on the account, if the credit balance was caused by:

a. having received payment from both DHP and another payer, or
b. duplicate payment from DHP, or
c. Having received an over payment form DHP.

Administrative Claim Appeals

An administrative claim appeal is a request for review of claim reimbursement, or denial, for technical and nonmedical reasons. All administrative claim appeals must be submitted in writing, along with supporting documentation for the appeal. See the DHP Administrative Claim Denial form in **Appendix**; submission of the form is encouraged but not required.

Appeal submissions must be received by DHP within one hundred and twenty (120) days from the Explanation of Payment (EOP) date. DHP will process the appeal and respond in writing, and/or or adjust any appropriate claim(s), within thirty (30) days from the receipt of the appeal. All administrative claim appeals must be finalized within twenty-four (24) months from the date of service.

Administrative claim appeals may be submitted to DHP:

DHP ADMINISTRATIVE CLAIM APPEAL SUBMISSION	
DHP Provider Portal:	www.driscollhealthplan.com
Email:	DHP.PortalAppeals@dchstx.org
Fax:	361-808-2776
Mail:	Attention: Claims Appeal Department P.O. Box 3668 Corpus Christi, TX 78463-3668

Field Requirements for Paper CMS-1500 Forms

For a complete listing of all field requirements for CMS-1500 forms, please refer to the Claims Companion Guides located on the DHP website at **www.driscollhealthplan.com**.

Field Requirements for Paper CMS-1450 (UB04) Forms

For a complete listing of all field requirements for CMS-1450 forms, please refer to the Claims Companion Guides located on the DHP website at **www.driscollhealthplan.com**.

Field Requirements for EDI 837 Electronic Claims

For a complete listing of all field requirements and a thorough Claim Companion Guide for the 837 Electronic Claims Submissions, please refer to the Claims Companion Guides located on the DHP website at **www.driscollhealthplan.com**.

NDC's Required on All Claims for Provider and Physician Administered Drugs

A physician-administered drug is any drug or vaccine billed for reimbursement using a HCPCS code and a provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant). This includes, but is not limited to, all "J" codes and drug-related "Q" codes. DHP requires national drug codes (NDC's) on ALL medical claims for physician and provider-administered drugs. Effective March 1, 2012, DHP will deny or reject the entire claim for any physician or provider-administered drug when it is missing NDC information or the NDC is not valid for the corresponding Health Care Common Procedure Coding System (HCPCS) code. This includes HCPCS and NDCs not listed on the Noridian or supplemental crosswalk provided by the Texas Medicaid Health Care Partnership (TMHP). For information about NDCs identified by the Centers for Medicare and Medicaid Services (CMS), please visit the CMS Medicaid Drug Rebate Program Data website. The most recent CMS NDC data file called, "rebate drug product data file," is included on this webpage and is updated quarterly. NDCs for provider-administered drugs are also included in this file.

Please remember the following to help ensure proper submission of valid NDCs and related information:

- The NDC must be submitted along with the applicable HCPCS procedure code(s).
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters).
- The NDC must be active for the date of service.
- The appropriate qualifier, unit of measure, number of units, and price per unit also must be included, as indicated below.

ELECTRONIC CLAIM GUIDELINES

Field Name	Field Description	ANSI (Loop 2410) - Ref Desc
Product ID Qualifier	Enter N4 in this field.	LIN02
National Drug CD	Enter the 11-digit NDC (without hyphens) assigned to the drug administered.	LIN03
Drug Unit Price	Enter the price per unit of the product, service, commodity, etc.	CTP03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given. (Values: F2 – international unit; GR – gram; ML – milliliter; UN – unit)	CTP05-1

If you have any questions about how to include the NDC code on your electronic claims, contact your clearinghouse.

PAPER CLAIM GUIDELINES

In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left- justified), immediately followed by the NDC. * Next, enter the appropriate qualifier for the correct 15:38:36 dispensing unit (F2 – international unit; GR – gram; ML – milliliter; UN – unit), followed by the quantity and the price per unit, as indicated in the example below.

**Note: The HCPCS/CPT code corresponding to the NDC is entered in field 24D. Example:*

CMS-1500: In the **shaded portion** of line-item field 24A-24G, enter NDC qualifier **N4** (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units).

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409476586 ML120													N		12345678901
01	01	13	01	01	13	11		J0744		1	17.94	6	N	NPI	123456789

UB-04: In line-item field 43, enter NDC qualifier N4 (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units).

42. Rev. CD	43. Description	44. HCPCS/Rate	45. Serv Date	46. Serv. Units
636	[60126598741][UN][1111.234]	HCPCS code	07/01/2008	HCPCS unit

↑ 11 digit NDC ↑ Unit of Measurement Qualifier* ↑ Unit Quantity

For additional CMS-1500 details, refer to the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available on the NUCC website at **nucc.org**.

Prior Authorization Requirements

A list of Prior Authorization requirements may be found on the Driscoll Quick Reference Tool (QRT) provided to providers during training and updated via fax blast or online at **www.driscollhealthplan.com**.

When a Prior Authorization is requested and returned as “Not Required” this does not mean the service is not covered, but that it does not require an authorization per DHP Authorization Guidelines. Contact Provider Services for assistance on any authorization requirements at the numbers indicated on the bottom of this page.

SECTION IX

DHP Quality Management

DHP Quality Management Program

Driscoll Health Plan's (DHP) quality management department promotes, supports and enhances enterprise-wide quality and safety improvement efforts to ensure optimal outcomes for members and providers. DHP is URAC accredited and adheres to a plan-wide quality management framework for care and services. DHP's Quality Assurance and Process Improvement (QAPI) Program addresses both clinical and non-clinical aspects of service, including availability, accessibility, coordination and continuity of care. The QAPI program is designed to assist Members of Driscoll Health Plan in receiving appropriate, timely, and quality services rendered in settings suitable to their individual need while promoting primary preventative care in an effort to achieve optimal wellness.

Authority for the QAPI Program comes from the DHS Board of Directors. The Board of Directors receives annual reports from the Executive Quality Committee regarding the effectiveness of the QAPI Program.

Annually, a Quality Management Work Plan is developed to identify areas to monitor for the coming year. The Plan includes monitoring and evaluating the structure, process, and outcomes of the health plan's delivery system and identifying opportunities to improve care, efficiency or processes. The DHP Board of Directors approves the QM Work Plan.

DHP Executive Quality Committee

Driscoll Health Plan Executive Quality Committee (EQC) has oversight of the QAPI program through which it ensures that members/providers, internal and external stakeholders receive quality care and services. The EQC reports to the DHS Governing Board and is comprised of the Chief Medical Officer, DHP President/CEO, System CMO, Chairs of Credentialing and Peer Review and Physician Advisory Committees, Chief Financial Officer, Vice President of Provider Relations and Network Strategy, Vice President of Claims Administration, the Director of QM, and other members approved by the DHS Board. The Committee meets quarterly to oversee QAPI program activities.

DHP Provider Quality Measures

The QM Work Plan is reviewed annually and includes structure, process and outcome measures that assess the quality of care and service DHP provides. These measures include, but are not limited to, reviews of:

- Accessibility and Availability of Providers
- Member and Provider Complaints
- Administrative Appeals and Denials
- HEDIS® Quality Measures
- HHSC Performance Standards (including HEDIS®, CAHPS, PQI)
- Potentially Preventable Events
- Provider Satisfaction surveys
- Review of Denials and Appeals
- Medical and Behavioral Utilization Statistics
- Performance Improvements Projects and Quality Improvement Projects
- DHP STAR Kids Health Home
- Performance of Delegated Entities
- And other metrics identified by DHP leadership

Driscoll Health Plan monitors after hours' accessibility and appointment availability of Providers. Providers are expected to follow the standards as defined in *"Section III – Provider Responsibilities"* of this Provider Manual.

DHP Performance Measurements

Healthcare Effectiveness Data Information Set (HEDIS®) is a comprehensive set of standardized performance measures developed by the National Committee for Quality Assessment (NCQA) that measure and report quality of care. The State of Texas requires all health plans to annually report their performance on HEDIS® measures, some of which require a review of medical records to ensure that certain services were performed and documented. The following HEDIS® measures require medical record information if services are not captured on the claim:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Immunization Compliance (CIS, IMA)
- Prenatal and postpartum care (PPC)
- Comprehensive Diabetes Care (CDC)
- Controlling High Blood Pressure (CBP)

Submitting accurate and timely claims/encounter data can reduce the need for medical record review. DHP provides Ready Reference Guides to assist with accurate and efficient documentation; these guides are located on the DHP Provider Portal and are also available from your Provider Relations Representative. Additionally, DHP may pay incentives for the use of specific codes to document services rendered. DHP provides encounter data to the HHSC-contracted External Quality Review Organization (EQRO). The EQRO evaluates all STAR, STAR Kids and CHIP health plan claims and produces health plan report cards and HEDIS® outcomes data reports. For more information regarding HEDIS® Ready Reference Guides and payment incentives, contact Provider Services at the bottom of this page.

Provider Report Cards

Driscoll Health Plan prepares individual provider report cards that evaluate the provider's performance as it relates to the care of the Members. The information is compiled from claims data and is compared to like providers so that a peer-to-peer evaluation can be completed. For more information regarding the report card, the provider may contact Provider Services at the number listed at the bottom of this page.

Confidentiality

Each provider contracted with Driscoll Health Plan (DHP) must implement and maintain a policy which acts to ensure the confidentiality of patient information as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information technology for Economic and Clinical Health Act of 2009 ("HITECH"), and other applicable federal and state laws.

Only health care providers treating a member and DHP employees that are involved in the members' treatment are allowed to access patient medical records and member-specific information. All member-specific information shall be maintained in a secure area at DHP offices. Written exchange of member-specific information is permitted when used for purposes of treatment, payment or healthcare operational procedures. Some examples are:

- To produce reports, or to conduct consultations that are required as part of DHP Service Coordination, Utilization Management, Care Coordination, Credentialing, Provider or Health Plan Performance Evaluation
- Between health care providers involved in the member's care.
- Between other health care providers involved in the direct care for a member at inpatient or outpatient facilities.

All DHP records are the property of DHP. They may be removed from DHP property only in accordance with applicable federal and state laws, including but not limited to court order or subpoena. Copies of hospital medical records of DHP members are released according to the policies and procedures of the Medical Records Department of the particular institution and their contract with DHP. Copies of the physician office medical records may be released in compliance with

applicable federal and state laws and regulations, and the terms of the individual or group physician contract with DHP.

Unauthorized release of confidential information by an employee or agent of DHP will result in disciplinary action, in compliance with Driscoll Health System Policy. Confidential information that is no longer is needed must be completely and properly destroyed (shredded, electronically deleted, etc.)

Health Insurance Portability and Accountability Act (HIPAA)
The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. HIPAA 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.

Driscoll Health Plan (DHP) and their contracted participating providers conduct business in a manner that safeguards member information in accordance with HIPAA Privacy regulations. Contracted providers must implement procedures that demonstrate compliance with these HIPAA Privacy regulations.

The HIPAA Privacy Rule requires the application of "Minimum Necessary", which means to limit the amount of information required to the minimum amount necessary to accomplish the intended purpose of the use or disclosure. Likewise, network providers should only request the minimum necessary amount of member information required to accomplish their intended purpose of the use or disclosure when contacting us. HIPAA privacy regulations allow sharing of member information (such as a member's medical record), which we may request to conduct business and make decisions about care, make an authorization determination, or to resolve a payment appeal. These types of requests are considered part of the HIPAA definition of "*treatment, payment or health care operations" ("TPO").*

Providers should safeguard fax machines used to transmit and receive medically sensitive information. When faxing information to us, always verify the receiving fax number is correct before sending, notify the appropriate staff at DHP, and verify that the fax was received.

Internet email should never be used to send files containing member information to us (example; excel spreadsheets with claim information), unless you can ensure that the email is sent to us encrypted, and only after you verify and type the correct email address you are sending to.

When mailing medically sensitive information such as medical records, the information should be in a sealed envelope marked confidential and addressed to the correct recipient at DHP.

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.

Protected Health Information (PHI)
Protected Health Information ("PHI") is information that is transmitted or maintained (held) in electronic, paper or oral form, that identifies an individual (based on 18 possible identifiers), and that relates to a past, present or future physical or mental health condition of that individual. To ensure that PHI is not sent to the wrong individuals or entities, providers and facilities are required to verify all member information received from Driscoll Health Plan, including the member's full name, date of birth and Medicaid ID number. Providers or facilities that are not involved with the member's treatment should not be receiving their PHI. The wrong provider or facility may receive a member's PHI by mail, fax, email or electronic remittance advice. Providers and facilities receiving a member's PHI in error are required to notify the Driscoll Health System Chief Privacy Officer immediately upon discovery to the confidential email address privacy@dchstx.org, and to promptly destroy (shred) the PHI. We will send you a confidentiality attestation to sign, stating that the PHI was destroyed, and that it will not be further used or disclosed. Providers or facilities are never permitted to use or disclose member PHI in a manner not permitted by the HIPAA Privacy Rule. Please call our Customer Service Team at **1-877-220-6376** for Nueces SA or **1-855-425-3247** for Hidalgo SA for assistance.

Focused Studies and Utilization Management Reporting Requirements

In conjunction with the QM Work Plan, Driscoll Health Plan conducts focused studies to review the quality of care (QOC) provided to members. An example of a focused study is asthma care and treatment.

Other Utilization Management reports that are produced monthly and reviewed at the Clinical Management Committee meetings, as well as the Performance Excellence Committee are as follows:

- Review of admissions and admission/1,000 Members (Medical and Behavioral Health)
- Review of bed days and bed days/1,000 Members (Medical and Behavioral Health)
- Average length of stay for inpatient admissions (Medical and Behavioral Health)
- ER utilization and utilization/1,000 Members
- Denials and appeals
- Other reports as needed to evaluate utilization of services by Membership

For information on any of the above reports, or to see one of these reports, contact the Director of QM for DHP at **1-877-324-7543**, or directly at **361-694-6371**.

Practice Guidelines

Driscoll Health Plan utilizes the American Academy of Pediatrics Practice Guidelines, as guidelines for care of pediatric Members. For adult members, we utilize the U.S. Preventative Task Force.

In addition, DHP uses the asthma practice guidelines from the National Heart Lung and Blood Institute. The immunization guidelines are followed as recommended by the Centers for Disease Control and Prevention (CDC) - Advisory Committee on Immunization Practices (ACIP).

The following tool kits have been developed and are available to our providers. They are:

- **The Obesity Toolkit** - developed by the Texas Pediatric Society and the Texas Chapter of the American Academy of Pediatrics.
- **The Asthma Toolkit** - developed by the Asthma Coalition of Texas.
- **The Diabetes Toolkit** - developed by the Texas Diabetes Council.
- **The Attention Deficit Hyperactivity Disorder (ADHD) Toolkit** - developed by the American Academy of Pediatrics.

For questions regarding the Practice Guidelines, or to request a tool kit, please contact DHP Provider Relations at the phone number listed at the bottom of this page.

SECTION X

Credentialing and Recredentialing

Initial Credentialing Information

Providers wishing to contract as a Participating Provider with DHP should visit https://driscollhealthplan.com/for-providers/ to obtain the Request to Contract form and submit your request via e-mail to DHPContracting@dchstx.org. In order to begin contracting and credentialing with DHP, a Request for Contract (RFC) form and current W9 must be completed and sent to DHPContracting@dchstx.org. Please note that all sections of the RFC must be completed, and a new form is required for each provider and location requested.

DHP will respond with a proposed contract and credentialing requirements to start the process of contracting and credentialing with DHP.

As a Medicaid managed care organization, Driscoll Health Plan must utilize the Texas Association of Health Plans' (TAHP) contracted Credentialing Verification Organization (CVO) Verisys as part of its credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. At least once every three years, Driscoll Health Plan must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the network.

Upon determination by the CVO that your application is complete, the credentialing process for new providers may take up to 90 days to be completed dependent upon Provider Type, Site Survey if applicable, and other requirements that must be completed.

DHP Provider Credentialing and Recredentialing Information

Credentialing and Peer Review Committee

The Credentialing and Peer Review Committee is responsible for approval of providers to the Driscoll Health Plan network. The Committee meets as often as necessary to review provider credentialing/recredentialing activities. The main scope of the committee is to ensure that competent qualified physicians and providers are included in DHP network and to protect the Members from professional incompetence.

Provider Site Reviews

Site visits may be conducted at the offices of all Primary Care Provider (PCP)'s, OB/GYN physicians, and behavioral health providers and other providers at the discretion of DHP prior to initial credentialing or at any time for cause, including a complaint made by a Member or another external complaint made to Driscoll Health Plan. The site visit review will consist of the following components:

- Physical Structure and Surroundings
- Safety
- Provider Accessibility
- Provider Availability
- Staffing
- Emergency Preparedness
- Treatment Areas
- Medication
- Infection Control
- Patient Education / Patient Rights
- Medical Record Review

For Mid-Level Practitioners (Nurse Practitioner or Physician Assistant), a site visit will be conducted that includes:

- Evidence of current state licensure for the Nurse Practitioner (Advance Practice Nurse) and Physician Assistant;
- Evidence of protocols or orders in place to provide medical authority and prescriptive authority;
- Verification that these protocols or orders are signed by the Supervising Physician and reviewed annually; and
- Evidence that the Nurse Practitioner or Physician Assistant has given a daily report to the Supervising Physician if there are complications.

Required Office Policies & Procedures

Driscoll Health Plan requires that network providers have Policies & Procedures in place for:

Advance Directives: Information on Advance Directives must be provided to any DHP Member 18 years of age or older.

Oversight of Mid-Level Practitioners: Policies defining the role of Mid-Level Practitioners in providing health care within their scope of practice must be in place at the provider's office.

Medical Record Confidentiality: A policy which acts to ensure the confidentiality of patient information as required by applicable federal and state laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Release of Records: A policy directing the provider's staff to follow a specific process for release of records that complies with applicable federal and state laws, including HIPAA.

Authorization for Treatment and Informed Consent: A policy for obtaining authorization for treatment and informed consent. A written authorization for treatment is a general consent required, indicating a patient's expressed or implied permission for a health care provider to perform routine care and treatment.

Medical Records Retention and Destruction: A written policy regarding the maintenance, retention, preservation, proper disposal and safeguard against loss or unauthorized use of the medical records, in accordance with applicable federal and state laws, including HIPAA.

Credentialing and Recredentialing Requirements

The following information is currently required for credentialing and recredentialing. The DHP Credentialing Specialist or the CVO will be requesting the following information for the credentialing and recredentialing process.

- Current Texas medical license or appropriate Texas license;
- Current DEA license;
- Current active clinical privileges at the primary network admitting facility; or,
- An agreement with a hospitalist group
- Malpractice/Liability Insurance declaration page with minimum coverage of $100,000/$300,000 or as required by the primary admitting facility and expiration date*;
- National Practitioner Data Bank inquiry;
- Board certification if newly certified or recertified since last credentialing Sanction inquiry (Medicare and Medicaid);
- Any additional medical diplomas and/or certificates; Malpractice history; and
- International medical graduates must submit a copy of their certification certificate by ECFMG (Educational Commission for Foreign Medical Graduates)
- A current, signed attestation statement by the applicant regarding:
  - Reasons for inability to perform essential functions of the position, with or without accommodations;
  - Lack of present illegal drug use;
  - History of loss or limitation of privileges or disciplinary activity;
  - History of loss of license and felony convictions;

- Current malpractice insurance coverage; and
- The correctness and completeness of the application.

In addition, Driscoll Health Plan must be notified by the provider whenever any of the following occurs:

- Malpractice settlements
- Any disciplinary actions taken (i.e. from hospital where physician has privileges, from state medical board, etc.)
- Change in malpractice coverage
- Loss of medical license

For a complete list of current recredentialing requirements, please contact the DHP at DHPContracting@dchstx.org.


TEXAS STAR
Your Health Plan ★ Your Choice


TEXAS
STAR Kids
Your Health Plan ★ Your Choice

SECTION A

Eligibility of Members

HHSC Determines Eligibility

The Texas Health and Human Services Commission (HHSC) is responsible for determining CHIP, STAR and STAR Kids eligibility. For information regarding eligibility, contact HHSC STAR hotline at **1-800-964-2777**.

For other help, call DHP Member Services at the numbers below:

STAR (Nueces)	STAR (Hidalgo)	STAR Kids (Nueces)	STAR Kids (Hidalgo)
1-877-324-3627	1-855-425-3247	1-844-508-4672	1-844-508-4674

Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP, STAR and STAR Kids. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure that all required documentation and forms are gathered. Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on the available health plans in each area. The enrollment broker receives each Member's plan and Primary Care Provider (PCP) selection documentation and notifies health plans of their new Members.

General Eligibility for STAR and STAR Kids /Medicaid

STAR & STAR Kids Members receive a Medicaid card from the State. To confirm member eligibility, providers may contact DHP:

STAR (Nueces)	STAR (Hidalgo)	STAR Kids (Nueces)	STAR Kids (Hidalgo)
1-877-324-3627	1-855-425-3247	1-844-508-4672	1-844-508-4674

DHP Website: www.driscollhealthplan.com

Providers may also call the state Automated Inquiry System (AIS) at **1-800-925-9126**. Currently, Members are enrolled for a twelve (12) month period. Providers may also verify eligibility on the DHP Provider Portal.

If a STAR Member loses his/her Medicaid card, he/she may obtain a temporary Medicaid form. This form is called a Temporary ID (Form 1027-A). More information regarding this temporary ID is available by calling the **STAR Help Line** at **1-800-964-2777.**

DHP also issues a Member ID card. An example of this card is included in **Appendix.**

***Note**: STAR Kids Dual Eligible Members will not have a PCP listed; Medicare is primary.*

If a Member becomes temporarily (for six (6) months or less) ineligible for Medicaid and regains eligibility status during the initial six-month timeframe, the Member will be automatically re- enrolled in the health plan they were in when eligibility was lost.

The geographic area served by DHP is a mandatory enrollment area. All persons eligible for Medicaid in the Temporary Aid to Needy Families (TANF) category or in the child categories, must enroll in a health plan and select a Primary Care Provider (PCP) who participates in that health plan's network.

Verifying Member Medicaid Eligibility and DHP Enrollment

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 Medicaid eligibility and DHP enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Use TexMedConnect on the TMHP website at **www.tmhp.com**
- Log into your TMHP user account and accessing Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- 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 patient's eligibility becomes an issue.

Providers access to Medicaid Medical and Dental Health Information

Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information.
- A viewable and printable Medicaid Card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at www.YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card
- See their medical and dental plans
- See their benefit information
- See Texas Health Steps Alerts
- See broadcast alerts
- See diagnosis and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see their available medical and dental information.

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

Newborn Eligibility

Newborns will be automatically enrolled in the mother's plan for the first 90 days following birth. The mother's plan will help her choose a Primary Care Provider (PCP) for the newborn prior to birth or as soon as possible after the birth.

Once a Medicaid eligible baby's birth is reported, HHSC will issue the newborn a Medicaid ID number. If a newborn's state issued Medicaid ID number is not available, DHP will issue a temporary (proxy) number for the newborn until the state-issued ID number is available.

All claim filing deadlines remain the same. To ensure all claims are paid timely and our members receive timely care, DHP asks all providers involved in the birth of newborns to assist and encourage the reporting hospitals, birthing centers, etc. to submit birth notifications to the state as soon as possible.

All newborns remaining in the hospital after the mother's discharge, or admitted to Level 2 nursery or higher, must have an authorization for inpatient care. Call DHP Health Services Department at **1-877-455-1053** immediately for authorization.

Span of Eligibility (Members' Right to Change Health Plans)

You can change health plans by calling the Texas MEDICAID MANAGED CARE Program Helpline at **1-800-964-2777**. However, you cannot change from one health plan to another health plan while you are in the hospital as a patient.

If you call to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

If you ask to change plans on or before April 15, the change will take place on May 1. If you ask to change plans after April 15, the change will take place on June 1.

Span of Coverage (Hospital) – Responsibility during a Continuous Inpatient Stay

If a Member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an Inpatient Stay, then the former STAR Kids MCO will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other Covered Services on the Effective Date of Coverage with the STAR Kids MCO.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member Moves from FFS to STAR Kids	FFS	New MCO
2	Member moves from STAR, STAR Health or STAR+PLUS to STAR Kids	Former MCO	New MCO
3	Member Moves from CHIP to STAR Kids	New MCO	New MCO
4	Adult Member Moves from STAR Kids to STAR or STAR+PLUS	Former STAR Kids MCO	New STAR or STAR+PLUS MCO
5	Member moves from STAR Kids to STAR Health	Former STAR Kids MCO	New STAR Health MCO
6	Member Retroactively Enrolled in STAR Kids	New MCO	New MCO
7	Member moves between STAR Kids MCOs	Former MCO	New MCO

[1] This document is not intended to supersede any HHSC Contract. This is a reference tool determining the span of coverage limitation. For up-to-date references, please see the STAR Kids Contract.

Disenrollment from Health Plan

STAR & STAR Kids/Medicaid

A request, by a Provider or by the health plan, to remove a Member from the Health Plan must be forwarded to HHSC. Providers must provide adequate documentation to justify disenrollment, and there must be sufficient compelling circumstances to warrant disenrollment. The Provider cannot make this request as retaliatory action against the Member. The Primary Care Provider (PCP) or other provider must submit medical records to justify the request.

Members may request disenrollment from managed care. This request must be accompanied by medical documentation from the Primary Care Provider or documentation that indicates sufficient compelling circumstances that merit disenrollment.

All requests and documentation will be forward to HHSC to make the determination. HHSC has the final decision authority.

SECTION B

STAR & STAR Kids/Medicaid Covered Services

STAR & STAR Kids /Medicaid Managed Care Covered Services

Driscoll Health Plan is required to provide specific medically necessary services to its STAR & STAR Kids Members.

"**Medically Necessary"** means:

1. Acute Care Services, other than behavioral health services, that are:
   a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
   b. provided at appropriate facilities and at the appropriate levels of care for the treatment of Member's health conditions;
   c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d. consistent with the diagnoses of the conditions;
   e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f. not experimental or investigational; and
   g. not primarily for the convenience of the Member or Provider; and

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

3. Children and Pregnant Women (CPW) services provides:
   a. services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to help them gain access to medical, social, educational, and other health-related services.
   b. For more information, call Driscoll Health Plan- Population Health Department at 1-877-222-2259 Monday - Friday, 8 a.m. to 5 p.m., Central Time.

STAR Kids benefits are governed by the MCO's contract with the Health and Human Services Commission (HHSC) and include medical, vision, behavioral health, pharmacy, and Long-term Services and Supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP.

The following table provides an overview of STAR & STAR Kids/Medicaid benefits. Please refer to the current Texas Medicaid Provider Procedure Manual available at **www.tmhp.com** and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of the covered services, limitations and exclusions for DHP STAR & STAR Kids members.

DHP also provides Long Term Services and Supports (LTSS) to STAR Kids and Medically Dependent Children's Program (MDCP) Members who are qualified and enrolled in MDCP program. LTSS covered services include Personal Care Services, Private Duty Nursing, Adaptive Aides, Minor Home Modifications, CFC benefits (Habilitation, Emergency Response Service, and Support management), Respite, Employment services (Supported Employment, Employment Assistance), Financial Management Services, Flexible Family Support Services, and Transition Assistance Services. The LTSS provider obtains prior authorization and coordinates delivery of services in collaboration with the Member, Member's PCP, and DHP's Service Coordinator and any other multidisciplinary provider.

https://driscollhealthplan.com/priorauthcheck/

STAR & STAR Kids /Medicaid Program Limitations and Exclusions

This list is from the *Texas Medicaid Provider Procedures Manual*. This list is ***not*** all-inclusive.

- Autopsies
- Biofeedback therapy
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection *(chymodiactin, chymopapain)*
- Custodial care
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid *(these limitations do not apply to services provided through the Texas Health Steps Program)*
- Immunotherapy for malignant diseases
- Immunotherapy for the treatment of atopic dermatitis
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for the mentally retarded
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition
- Joint sclerotherapy
- Keratoprosthesis/refractivekeratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- Obsolete diagnostic tests
- Oral medications, except when billed by a hospital and given in the emergency room or the inpatient setting *(hospital take-home drugs or medications given to the client are not a benefit)*
- Orthotics *(except CCP)*
- Outpatient and nonemergency inpatient services provided by military hospitals
- Oxygen *(except CCP and home health)*
- Parenting skills

- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
- Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as Xylocaine, inhalants, surgical trays, or dressings, are included in the surgical payment.
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
- Private room facilities except when a critical or contagious illness exists that results in disturbance to other patients and is documented as such when it is documented that no other rooms are available for an emergency admission, or when the hospital only has private rooms
- Procedures and services considered experimental or investigational
- Prosthetic and orthotic devices *(except CCP)*
- Prosthetic eye or facial quarter
- Quest test *(infertility)*
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients.
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies not reasonable and necessary for diagnosis or treatment
- Services or supplies not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body Member, or when prior authorized for specific purposes by TMHP *(including removal of keloid scars)*
- Services or supplies provided outside of the U.S., except for deductible and coinsurance portions of Medicare benefits as provided for in this manual
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services provided by an interpreter (except sign language interpreting services requested by a physician)
- Services provided by ineligible, suspended, or excluded providers
- Services provided by the client's immediate relative or household Member
- Services provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations *(including vasectomies)* unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent *(This policy complies with 42 CFR §441.250, Subpart F)*
- Take-home and self-administered drugs except as provided under the vendor drug or family planning pharmacy services
- Tattooing *(commercial or decorative only)*
- Telephone calls with clients or pharmacies *(except as allowed for service coordination)*
- Thermogram

- Treatment of flatfoot conditions for solely cosmetic purposes and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot

Removal of the Inpatient Spell of Illness Limitation
STAR and STAR Kids members are not limited to the 30-day spell of illness.

Annual Dollar Limit for Inpatient Services
The $200,000 annual limit for inpatient services does not apply to STAR and STAR Kids members.

Medically Necessary Prescription Drugs for Adults
STAR Kids members not covered by Medicare and STAR Members who are 21 years of age or older may receive unlimited medically necessary prescription drugs.

DHP Value Added Services
In addition to the benefits for STAR and STAR Kids, DHP provides certain value added services for Members (see **Appendix** for the DHP value added services).

Family Planning Services
Family Planning services, including sterilization, are covered STAR & STAR Kids Member benefits. These services may be provided by any qualified HHSC approved family planning provider (regardless of whether or not the provider is in network for DHP) without the prior approval from the Primary Care Provider (PCP) or DHP. Family planning providers must deliver family planning services in accordance with the HHSC Family Planning Service Delivery Standards. Family planning services are preventive health, medical, counseling and educational services that assist Members in controlling their fertility and achieving optimal reproductive and general health. Family planning services must be provided by a physician or under physician supervision.

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

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

Sterilization services are a benefit. In the event that a DHP Member aged 21 years or older chooses sterilization, providers must complete the current state-approved sterilization consent form at least 30 days prior to the procedure, with some exceptions related to emergency surgery and premature delivery. These forms and instructions are available in both English and Spanish at **www.tmhp.com** by clicking on the Family Planning link under the Provider section.

Providers must include the sterilization consent form with the completed claim form. No authorization is required for family planning services, including sterilization.

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

What is NEMT?

NEMT services provide transportation to covered health care services for Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places where an individual receives Medicaid services. NEMT services do NOT include ambulance trips. Driscoll Health Plan (DHP) has partnered with SafeRide Health to provide transportation services for our members.

What services are part of NEMT Services?

- Passes or tickets for transportation, such as mass transit within and between cities or states, including by rail or bus, included in certain circumstances.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered
  health care service. The ITP can be the member, 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.
- 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.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If a member needs assistance while traveling to and from their appointment, NEMT services 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 of age must be accompanied by a parent or guardian or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a member would benefit from receiving NEMT services, please refer them to the Driscoll Health Plan at 1-877-324-7543 or SafeRide Health at 1-833-6394-5881 for more information.

For billing or claims information related specifically to NEMT services, contact SafeRide Health at 1-833-694-5881.

What are Driscoll Health Plan Transportation Value-Added Services?*
Driscoll Health Plan offers additional transportation benefits to members. Members can request a ride to their local food pantry, local grocery store, DHP health education class, DHP community events, Social Security Administration office, and DHP-sponsored events. * Restrictions and limitations may apply.

Members can request a ride by contacting SafeRide Health at 1-833-694-5881.

Dental Managed Care Covered Services

Dental Managed Care Services are not provided by DHP. However, DHP will assist the Member in obtaining the following services, including Texas Health Steps Services/orthodontia. Providers should visit **www.tmhp.com** for additional information contained in the TMPPM.

Primary and Preventative Dental Services

Pediatric (under age 21) dental services for STAR Members are a covered benefit, except Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members, aged 6 through 35 months.

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 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**.

Coordination with Non-Medicaid Managed Care Covered Services

Non-Medicaid Managed Care Services are not provided by DHP *(for additional information reference the Texas Medicaid Provider Procedure Manual (TMPPM)*). However, DHP will assist the STAR and STAR Kids Member in obtaining the following Non-Medicaid Managed Care Services:

Texas Health Steps Environmental Lead Investigation (ELI)

DHP educates Providers about blood lead level reporting under Texas Health & Safety Code Chapter 88 and 25 Tex. Admin. Code Chapter 37, Subchapter Q; coordination with the Texas Childhood Lead Poisoning Prevention Program at DSHS; and appropriate follow-up testing and care, including the Centers for Disease Control and Prevention guidelines located at **http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf**. DHP provides coverage for lead screening, follow-up testing, and environmental lead investigations, whether as Non-capitated services or Covered Services.

Early Childhood Intervention (ECI) Specialized Skilled Training (SST) and Targeted Case Management

DHP Network Providers are educated regarding the federal laws on child find and referral procedures (e.g., 20 U.S.C. § 1435(a) (5); 34 C.F.R. § 303.303). DHP requires Network Providers to identify and provide ECI referral information to the LAR of any Member under the age of three suspected of having a developmental delay or otherwise meeting eligibility criteria for ECI services in accordance with 40 Tex. Admin. Code Chapter 108 within seven calendar days from the day the Provider identifies the Member. DHP permits Members to self-refer to local ECI Providers without requiring a referral from the Member's PCP. If requested by the Member's LAR, DHP will provide educational materials developed or approved by the Department of Assistive and Rehabilitative Services - Division for Early Childhood Intervention Services for these children.

DHP's Service Coordinators will identify STAR Kids members under the age of 3 yrs. old for ECI Services and make referrals as appropriate. DHP's Service Coordinator will offer Service Management and develop a Service Plan as appropriate for these Members and coordinate with the PCP and other providers. With the consent of the Member's authorized representative, the Service Coordinator will include key information from the IFSP in the development of the Member's Service Plan. The Service Coordinator will provide the PCP with information about the ECI location and contact information in their Service Area (SA) for referral and assist the providers in obtaining the necessary services.

DHP ensures the Member's LAR that ECI participation is voluntary. DHP will provide medically necessary services to a Member if the Member's LAR chooses not to participate in ECI.

DHP contracts with an adequate number of qualified ECI Providers to provide ECI Covered Services to Members under the age of three who are eligible for ECI services. DHP allow an Out- of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the Individual Family Service Plan (IFSP).

ECI: SST
Specialized Skills Training (SST) is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

- SST services must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter E. Documentation of each SST visit must comply with 40 TAC, Part 2, Chapter 108, Subchapter E, §108.501.
- SST services must be identified on the IFSP and have been recommended by a licensed practitioner of the healing arts (as defined in 40 TAC, Part 2, Chapter 108, Subchapter A, §108.103).
- SST services may be performed in an individual or group setting.
- Services must include all the following:
    - Be designed to create learning environments and activities that promote the client's acquisition of skills in one or more of the following developmental areas: physical or motor, communication, adaptive, cognitive, and social or emotional.
    - Include skills training and anticipatory guidance for family members, or other significant caregivers, to ensure effective treatment and to enhance the client's development.
    - Be provided in the client's natural environment, as defined in 34 CFR Part 303, unless the criteria listed at 34 CFR §303.167 are met and documented in the client's record.
    - In addition to the criteria noted above, services performed in a group must include all the following:
    - Recommended by the interdisciplinary team and documented on the IFSP, only when participation in the group will assist the client reach the outcomes in the IFSP.
    - Planned as part of an IFSP that also contains individual services.
    - Be limited to no more than four clients and their parent(s) or other significant caregiver(s).

Providers must submit procedure code T1027 for SST services, which are billed in 15-minute increments. Providers must submit procedure code T1027 when services are performed in a group setting or T1027 with modifier U1 when performed in an individual setting.

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

ECI; TCM
Targeted Case Management (TCM) services are provided to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services.

Providers may perform and submit claims for TCM services after the client's ECI eligibility has been established. The IFSP does not have to be completed before providers may perform TCM services and submit claims to Texas Medicaid. DARS provides additional guidance to ECI contractors about requirements for including ongoing case management services on the IFSP.

Providers must use procedure code T1017 when billing for TCM services, which are billed in 15- minute increments.

TCM services may be delivered face-to-face or by telephone. Providers must use procedure code T1017 for telephone interaction and T1017 with modifier U1 for face-to-face interaction. The POS is determined by the service coordinator's location at the time the service is rendered.

Claims may be submitted when the interaction is with the client or the client's parent(s) (as defined in 10 United States Code (U.S.C.) §1401) or other routine caregiver(s), or occurs in the presence of the client or the client's parent(s) or other routine caregiver.

Providers may contact other individuals to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services, to help identify the eligible client's needs, to assist the eligible client in obtaining services and to receive useful feedback and alert the service coordinator to changes in the eligible client's needs. These contacts must be documented in the client's record, but claims may not be submitted for reimbursement unless the contacts occur in the presence of the client and the client's parent(s) or other routine caregiver.

TCM must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter D.

All documentation must be retained in the client's record and available upon request. The documentation must be in compliance with 40 TAC, Part 2, Chapter 108, Subchapter D, §108.415.

TCM services are provided by an ECI provider. The ECI provider ensures that TCM services are provided by a service coordinator who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.315

Schools Health and Related Services (SHARS)

Texas School Health and Related Services (SHARS) for children under age 21 with disabilities who need audiology services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, school health services, assessment and counseling.

Mental Health Rehabilitation Services (MHR) and Mental Health Targeted Case Management (TCM)

Mental health rehabilitative services and mental health targeted case management are available to DHP Medicaid recipients who are assessed and determined to have:

Severe and Persistent Mental Illness (SPMI)
Individual age 18 years or older: Severe and persistent mental illness is the most serious and debilitating form of mental illness, causing lasting, disabling disturbances in thinking, feeling, and relating. Some examples of SPMI are Schizophrenia, Bipolar Disorder, and Major Depression.

Severe Emotional Disturbance (SED
Individual birth to 18 years old. Severe Emotional Disturbance is a diagnosed mental health disorder that substantially disrupts a child's or adolescent's ability to function socially, academically, and emotionally.

Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services are available to eligible STAR Kids Members who have serious and persistent mental illness (SPMI) and children with a severe emotional disturbance (SED) in able gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to the recipient's mental health needs. Qualified entities can include both Local Mental Health Authorities (LMHA's) and other entities, such as multi-specialty groups that employ providers of these services.

Mental Health Rehabilitative Services include training and services that help the Member maintain independence in the home and community, such as the following.

1. **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.

2. **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.

3. **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.

4. **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.

5. **Day program for acute needs** – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms of prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting.

DHP provides Mental Health Rehabilitative Services and Mental Health Targeted Case Management in accordance with UMCM Chapter 15, including ensuring providers meet all training requirements and the use of the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG), and must ensure that it coordinates with providers of Mental Health Targeted Case Management to ensure integration of behavioral and physical health needs of Members.

Additionally, DHP ensures the following:

1. Providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use, and are trained and certified to use, HHSC approved assessment tools such as the Child and Adolescent Needs and Strengths (CANS) assessment and Adult Needs and Strength Assessment (ANSA) for assessing Member's needs.

2. STAR Kids Service Coordinators coordinate with LMHA's, State psychiatric facilities and providers of Mental Health Targeted Case Management and Mental Health Rehabilitative Services to ensure the integration of behavioral and physical health needs of Members.

3. STAR Kids Service Coordinators refer Members that lose Medicaid eligibility to the Local Mental Health Authorities for indigent mental health services.

Required DHP Notification from LMHA's:

- Providers providing the services noted above are required to submit Notifications (Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form) via the DHP Portal or Fax to DHP. Authorization for Outpatient BH Services are not required.
- Billing Notes:
  - All services are billed with 1 Unit = 15 minutes Except Day Program Services in which 1 unit = 45 to 60 Minutes.
  - Rendering Provider for the above services should reflect the LMHA's Group NPI *(Same NPI as the Provider is billing)*.
  - Claims should be filed on a CMS-1500.

Department of Assistive and Rehabilitative Services (DARS) Blind Children

The Department of Assistive and Rehabilitative Services may provide additional case management services for the blind and visually impaired Members. This is limited to one contact per client, per month. The main office in Austin may be contacted at **1-800-252-5204**.

Tuberculosis Services Provided by DSHS Approved Provider

All confirmed or suspected cases of Tuberculosis (TB) must be referred to DSHS using the forms and procedures for reporting TB adopted by DSHS. DHP will assist providers in referring to the Local Tuberculosis Control Health Authority within one (1) day of diagnosis for a contact investigation. The provider must document the referral to the local health authority in the Member's medical records that may be reviewed by DSHS and the local authority. Providers should notify DHP on any referral made to the local health authority.

DHP must coordinate with the local health authority to ensure that Members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. DHP will report any Member who is non-compliant, drug-resistant, or who is or may be posing a health threat to DSHS or the local authority. DHP will cooperate with the local health authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

DADS Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agents. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments). Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Preadmission Screening and Resident Review (PASRR)

PASRR is the prescreening assessment of an individual to identify whether the individual is suspected of having mental illness (MI), an intellectual disability (ID), or a development disability (DD) and to evaluate whether the individual needs nursing facility care and needs specialized services. DHP will follow any PASRR requirements when acting as a referring entity for Members as required by 40 Tex. Admin. Code §§ 17.101, 17.102(25), and 17.301.

Pharmacy Benefit Program

DHP administers the Pharmacy Benefit Program, effective March 1, 2012. DHP is contracted with a Pharmacy Benefits Manager (PBM), **Navitus Health Solutions, LLC**, to administer this program. The only drugs eligible for reimbursement are listed in the current Texas Formulary, formerly used by the Texas Vendor Drug Program. DHP is however, responsible for assisting its Members with medication management through the Primary Care Provider (PCP)'s and/or Specialty Care Providers. Some medications may require prior authorization. For information regarding which drugs require prior authorization, contact DHP Provider Services at the phone number at the bottom of this page. For more information, see *"Section VII - Pharmacy"* in this manual.

Member's Right to Designate an OB/GYN

DHP ***DOES NOT LIMIT*** TO NETWORK *(excludes STAR Kids Dual Eligible Members)*.

DHP allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's primary Care Provider or not. Authorization is required for out-of-network 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
- Referral to specialist doctor within the network

Pregnancy Notification Requirements

Pregnant STAR & STAR Kids Medicaid Members

DHP Health Services Department should be notified as soon as the Member is determined to be pregnant, as well as advised of any high-risk factors. This will allow the case managers to work collaboratively with the physician and provide proactive service coordination in order to help in maintaining a healthy full-term pregnancy.

Obtaining Pregnancy Notification Forms

Supplies of Pregnancy notification forms are available to provider's offices or see **Appendix** of this manual. Contact Provider Services at the phone number listed at the bottom of this page for information regarding these forms. These forms may be completed and faxed to the Population Health Department to notify DHP of a pregnant Member *(STAR Service Coordination fax number is **1-866-704-9824** and STAR Kids Service Coordination fax number is **1-844-381-5437**)*.

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born.

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage & Billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
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 **	
STAR Health	STAR Health	STAR Health	
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.

SECTION C

Texas Health Steps

What is Texas Health Steps?

Texas Health Steps (THSteps) Program (The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program) is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid -eligible clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps. The Texas Department of State Health Services (DSHS), by authorization of Texas Department of Health and Human Services (HHSC), operates and administers the outreach and informing, medical and dental checkup, dental treatment utilization components of this program. State authority is found in Title 25 Texas Administrative Code (TAC), Part 1, Chapter 33, Subchapter A, Rule §33.1.

*See: **http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx**, TEXAS HEALTH STEPS STATUTORY STATE REQUIREMENTS for more information.*

Texas Health Steps can help in many ways. Some of the things done in a Texas Health Steps medical checkup are:

- Physical exam, measuring height and weight
- Hearing and eye check
- Checking for a good diet
- Immunizations (when needed)
- Blood tests (when needed)
- TB risk assessment

How Can I Become a Texas Health Steps Provider?

All DHP Primary Care Providers (PCPs) must enroll to become a Texas Health Steps provider. Provider enrollment is handled by Texas Medicaid and Healthcare Partnership (TMHP), a State Medicaid Contractor., They have a website dedicated to provider enrollment that includes forms and instructions at **http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx**.

Finding a Texas Health Steps Provider

You may locate a Texas Health Steps provider by reviewing your DHP Provider Directory. All PCPs within this directory are Texas Health Steps providers.

Texas Health Steps Periodicity Schedule

Providers are required to follow the Texas Health Steps periodicity schedule, to ensure complete Texas Health Steps checkups. The periodicity schedule is available for download at **http://www.dshs.state.tx.us/Texas Health Steps/providers.shtm**.

Eligibility for Texas Health Steps Checkup

STAR and STAR Kids Members are periodically eligible for a Texas Health Steps checkup. Members should have a Texas Health Steps checkup within the year following their birthday or enrollment date.

Timely Texas Health Steps Checkup

DHP would like to assure STAR and STAR Kids members get a timely Texas Health Steps checkup within the year of their birthday or enrollment date. If the Member's birth date/eligible date is past and you do not have record of a Texas Health Steps checkup and the parent does not indicate they had one elsewhere, you need to complete the checkup. Providers who perform the checkup as indicated will be compensated by DHP for those services as set forth below.

Checkups Outside the Texas Health Steps Periodicity Schedule

Checkups provided when a Texas Health Steps checkup is not due as stated above, must be billed as an exception to the periodicity schedule. The claim must be submitted with the appropriate modifier. Payment will be made for these exceptions if the services are provided under the following categories:

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

Texas Health Steps Medical Checkup Components

Providers must ensure all required components of a Texas Health Steps medical checkup are performed and documented in accordance with the Texas Health Steps periodicity schedule.

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 records, 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 screens. 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 component. 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 require 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 Sates," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
- The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
- Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
- Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit http://www.dshs.texas.gov/immunize/tvfc/.

4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screen performed as 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 screening 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 health lifestyles 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 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 stablished. The parent or caregiver may self-refer for dental care at any age.

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

Children of Migrant Farmworkers

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

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

Vaccines for Children (VFC) Program

The Texas Vaccines for Children Program provides STAR& STAR Kids /Medicaid Members 18 years and younger. Free routinely recommended vaccines according to the American Academy of Pediatrics (AAP) immunization schedule. To obtain free vaccines, the provider must enroll in the VFC program through Department of State Health Services (DSHS). There is no reimbursement by DHP to providers for vaccines available from VFC. For more information, contact DSHS at **(512) 776-3711**, at **http://www.dshs.state.tx.us/immunize/tvfc/tvfc_about.shtm**, or Provider Services at the phone number below (see application form in **Appendix** of this manual).

Texas Health Steps Lab and Testing Supplies

Some specimens related to Texas Health Steps medical checkups must be submitted to the Texas Department of State Health Services (DSHS) Laboratory. The lab processes these tests at no charge to the provider. Lab test results are mailed or faxed back to the provider to share with the Member.

Specimens related to testing for HIV, Syphilis, Type 2 Diabetes, and Hyperlipidemia can be submitted to the DSHS Laboratory in Austin. Providers with a CLIA Certificate of Waiver may perform initial blood lead screening using a point-of-care test. The confirmatory specimen may be sent to the DSHS lab, or the client or specimen may be sent to a lab of the provider's choice.

Laboratory Services Contact Info:

Phone Toll Free:	**(888) 963-7111, ext. 7318**
Phone:	**(512) 776-7318**
Fax:	**(512) 776-7294**

For complete specimen collection instructions and addresses to submit specimens, go to:

http://www.dshs.state.tx.us/lab/cc_spec-col.shtm
http://www.dshs.state.tx.us/lab/labMailingShipping.shtm

Newborn Screens

All newborn screens must be sent to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. 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.

Laboratory tests that must be processed at the DSHS Laboratory cannot be billed as separate claims on the same date of service as a medical checkup paid by DHP.

All newly enrolled Teas Health Steps providers receive a startup package of forms and supplies. Included in this startup package are blood specimen collection supplies. Additional supplies may be requested from DSHS Laboratory Services via fax at **512-458-7672**.

Texas Health Steps Dental Screenings

Pediatric (birth through age 20) dental services for STAR Members are covered by Texas Health Steps. Routine dental exams and services are available beginning at age six (6) months and once every six (6) months thereafter. These dental services are covered by Texas Health Steps through HHSC, and not by DHP. Members can self-refer to participating dentists in Texas Health Steps. Neither a referral from the PCP nor authorization from DHP is necessary for routine dental services. To locate a participating Texas Health Steps dentist, please call **1-877-847-8377.**

Texas Health Steps dental providers should submit claims directly to the member's dental plan for processing. The member's dental plan should also be contacted concerning any prior authorization requirements for dental services. Anesthesia and facility claims for dental surgeries are covered by DHP and will be processed and paid by DHP for DHP Members.

Oral Evaluation and Fluoride Varnish

Oral evaluation and fluoride varnish is covered by DHP when provided in the PCP office for children from 6 to 35 months of age. Oral evaluation and fluoride varnish in the medical home has been established to support the dental home concept. The oral evaluation and fluoride varnish application must be performed during a Texas Health Steps medical checkup.

A dental evaluation includes the following:

- intermediate oral evaluation,
- fluoride varnish application, and
- a referral to a dental home beginning at six (6) months of age.

DSHS requires that physicians complete the required benefit education regarding an intermediate oral evaluation with fluoride varnish application. Once education is completed, the provider may be certified by DSHS Oral Health Program to perform this evaluation with dental varnish application by submitting a completed registration form and completion certificate via fax to (512) 776-7256. Training for certification is available as a free continuing education course on the Texas Health Steps website at **http://www.txhealthsteps.com/cms/**.

In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier and diagnosis code Z00121 or Z00129 when billing fluoride varnish. The oral evaluation/fluoride varnish must be billed with one of the following medical checkup codes 99381, 99382, 99391, or 99392. This service is limited to six (6) services per lifetime by any provider.

Federally Qualified Health Centers (FQHC) should refer to the Texas Medicaid Provider Procedures Manual for further instructions on billing.

Texas Health Steps Vision

Each Texas Health Steps checkup includes a vision screen based on the periodicity schedule. Texas Health Steps provides one (1) eye examination per state fiscal year (September through August) and eyeglasses every two (2) years. Any diagnosed conditions or abnormalities of the eye that require additional service beyond the scope of an exam for refractive errors must be referred back to the Member's PCP. Vision providers who provide additional services beyond refractive exams must have a prior authorization. Routine eye exams are provided through the DHP subcontractor, Envolve Vision of Texas. The web address is **https://visionbenefits.envolvehealth.com/logon.aspx**. For the full contact information, see the **Quick Reference Phone List** at the beginning of this manual.

Referral for Services Identified During a Texas Health Steps Checkup

Referrals for services identified during a Texas Health Steps checkup would occur as any other referral process. Contact the Utilization Management Department for more information regarding the referral process at the number listed at the bottom of this page. Also, see Texas Medicaid Provider Procedure Manual for more information regarding Texas Health Steps.

Outreach to Members for Texas Health Steps Checkups

DHP has an Outreach Call Center to help in making the Texas Health Steps appointments for STAR and STAR Kids Members. The call center helps with the following:

- Attempt to contact Members who are due for a Texas Health Steps checkup. Attempt to contact new Members who are due for a Texas Health Steps checkup.
- Once contacted, the Call Center will conference call the Member's PCP's office to help in scheduling the appointment for a checkup, while the Member is on the line.
- The Call Center will send out a reminder letter to the Member once the appointment for a checkup has been made.
- If unable to reach Member/parent by telephone, the Call Center will send them a postcard to remind them to call their PCP to schedule their child's Texas Health Steps checkup that is due.
- In addition, the Call Center helps Agricultural Worker children with acceleration of services prior to leaving the area, if needed.

The Call Center reaches out and schedules Texas Health Steps appointments for Members that are due a checkup.

SECTION D

STAR/STAR Kids Medicaid Appeals, Complaints, Peer-to-Peer Conversations, & State Fair Hearings

Peer-to-Peer Conversations

Peer-to-Peer conversations related to non-certification decisions are available to Providers, pre and post determination, and are the most timely and direct process to facilitate exchange of information in support of the authorization process. Peer clinical reviewers are available to discuss non-certification decisions with Attending Provider or other Ordering Providers via the Toll Free UM line at 1-877-455-1053 (CHIP/STAR/STAR Kids) or 1-844-406-5437 (STAR Kids LTSS) during normal business hours Monday - Friday from 8 a.m. to 5 p.m., except for legal holidays.

Peer-to-Peer Availability Prior to Decision

Driscoll Health Plan (DHP) affords the Provider with a reasonable opportunity to discuss the Member's treatment plan and the clinical basis of a non-certification decision with the original peer reviewer prior to issuing an adverse determination. The reasonable opportunity timeframe is defined as:

- One (1) Business Day for a routine, prospective review;
- Five (5) Business Days for a retrospective review; and
- Prior to issuing, for a concurrent or post-stabilization review.

If the original Peer Reviewer cannot be available within one (1) Business Day, another Peer Reviewer will be available for the conversation.

Peer-to-Peer Post-Decision

When DHP makes a non-certification decision, and no peer-to-peer conversation has occurred in connection with that case, DHP provides, within one (1) Business Day of a request by the Attending Provider or other Ordering Provider, the opportunity to discuss the non-certification decision:

- With the Clinical Peer Reviewer making the initial determination; or
- With a different Clinical Peer, if the original Clinical Peer Reviewer cannot be available within one (1) Business Day.

For CHIP, STAR and STAR Kids non-certification decisions, the *Peer-to-Peer Conversation Availability* form is sent via facsimile and/or the provider or facility receives notification via phone. Additionally, Peer-to-Peer Opportunity Offer for non-certification decisions is included in the *Notification of Referral Status* facsimile.

For STAR or STAR Kids members less than 21 years old, the Peer-to-Peer offer is also in the *Initial Request for Additional Information/Insufficient or Incomplete/Lack of Information* letter, if applicable.

If a peer-to-peer conversation or review of additional information does not result in an authorization (certification), DHP informs the Provider and Member of the right to initiate an appeal and the procedure to do so.

What is an Appeal?

An appeal is a request from the member or provider on behalf of the member to review the determination of a denial, reduction suspension or termination of a service. Appeals are processed in separate departments dependent upon the categorization of the appeal. DHP Member Services are available to assist members with the filing of a Member Appeal. This section outlines these processes.

Member Appeals

There are four (4) types of member appeals. They are:

1. *Member Adverse Medical Determination Appeal* - an appeal that occurs when there has been a denial of benefit due to lack of medical necessity.

2. *Emergency Appeal* - an appeal processed at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the Member's health.

3. *Administrative Denial Appeal*- a request for a review of an Administrative Denial, which has been denied for technical or non-medical reasons.

4. *Pharmacy Appeal*- an appeal that occurs when there has been a denial of pharmaceutical benefits from the preferred third party vendor from DHP.

What can I do if DHP denies or limits my Member's request for a covered service?

Filing a Member Appeal

A Member or Member's Legally Authorized Representative (LAR) may request an appeal with the Member's written consent. Appeals may be requested orally or in writing.

Submit Member Appeals as follows:

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2186 **Email:** DHP_QM_Appeals@dchstx.org
Mail: DRISCOLL HEALTH PLAN ATTN: Member Appeals Department 4525 Ayers Street Corpus Christi, Texas 78415	

How will I be notified if services are denied?

The Member/Provider is notified in writing of the denial of services within3 Business Days of the decision.

Can someone from DHP help me file an appeal?

A Member Advocate is available to assist with the filing of an appeal. This includes help with filing an Emergency Appeal.

Member Adverse Medical Determination Appeal Process

If the DHP Medical Director determines that requested services do not meet medical necessity criteria or if the request for services is not covered or limited, then services may be denied. In such case, a denial letter is sent to the Provider and Member setting forth the basis for the denial, along with the process to initiate an appeal.

A Member/Provider may submit an appeal orally or in writing 60 days from the date of the Denial of Action letter. An acknowledgement letter will be sent to the Member/Provider within five (5) Business Days of receipt of the appeal and a Peer-to-Peer Conversation Availability Notification will be sent to the provider of service.

In order to ensure that there is continuity of current authorized services, the Member, Provider, or someone acting on behalf of the Member, should file the appeal on or before the later of:

(a) 10 days following the mailing of the notice of action, or
(b) the intended effective date of the proposed action.

A Medical Appeal Reviewer of like specialty who did not participate in the original denial will review the appeal request. The entire process from receipt of the oral or written appeal to resolution will be completed within 30 calendar days. The timeframe may be extended up to 14 calendar days if the Member requests an extension, or if DHP shows that there is a need for additional information and how the delay is in the Member's interest.
Within two (2) calendar days from the decision to delay, DHP will give the Member written notice of the reason for delay if the Member has not requested the delay. Written notice will include the process to file a complaint if the member does not agree with the decision to delay.

Members may ask for a State Fair Hearing only at any time during or after the DHP appeal process. See information contained in the State Fair Hearing section of this manual.
Members may ask for an External Medical Review and a State Fair Hearing after DHP mails the appeal decision notice. See information contained in the External Medical Review section of this manual.

Members also have a right to request an appeal for denial of payment for services in whole or in part and should be submitted. Appeal for denials of service for non-covered benefits are considered complaints, and they are not eligible for appeal.

Members may be required to pay the cost of services furnished while the appeal is pending, if services were delivered before approval was given.

Emergency Appeal Process

Providers/Members may request an emergency appeal if he/she believes a Member's life or health could be jeopardized by the time frames involved in the normal appeal process. Providers/Members may file the request orally or in writing. During an emergency appeal, the DHP Chief Medical Officer or Clinical Appeal Reviewer who has not previously reviewed the case will review the appeal. DHP will complete investigation and resolution of an approved request with verbal and written notification of determination within 72 hours of request.

If a Member or a Member's representative disagrees with DHP decision, the individual has the right to ask for a State Fair Hearing after completing the DHP internal appeal process. If DHP has not sent a resolution in a timely manner or emergency appeal as stated in DHP policy, the Member or Member's representative may request an Emergency State Fair Hearing and does not have to exhaust DHP internal appeal process. See State Fair Hearing Information below.
DHP will make every effort to honor the Providers/Members request for an emergency appeal. If the rationale for the request does not meet the definition of an emergency appeal, DHP may deny the request for an emergency appeal. If this happens, the Provider may discuss the situation directly with the Medical Director by calling the Provider Services number listed at the bottom of this page.

Administrative Denial Appeal Process

Contractual Denials are denials based upon a Provider's failure to follow the terms and conditions of the Provider's contract with DHP and applicable policies and procedures include, but are not limited to:

- Failure to obtain prior authorization.
- Failure to notify DHP prior to transfer.
- Failure to notify DHP of a hospital admission within stated timeframes.

A Provider/Member may submit an appeal orally or in writing 60 days from the date of the Administrative Denial letter for technical and non-medical reasons. An acknowledgement letter will be sent to the Provider/Member within five (5) Business Days of receipt of the appeal. If the appeal is submitted orally, an appeal form will be sent to the Provider/Member with the acknowledgement letter. The appeal form must be completed, signed, and returned to DHP.

DHP will review the request for Administrative Denial Appeal and issue a response letter to the Provider, Member or Members representative with an explanation of the decision within thirty (30) calendar days.

Pharmacy Appeal Process

If the DHP preferred third party vendor pharmacy benefit managers (PBM) determines that requested services do not meet criteria or if the request for services is not covered or limited, then services may be denied. In such case, a denial letter is sent to the Provider and Member setting forth the basis for the denial, along with the process to initiate an appeal. Providers/Members may submit an appeal orally or in writing 60 days from the date of the Denial of Action letter. An acknowledgement letter will be sent to the Provider/Member within five (5) Business Days of receipt of the appeal. If the appeal is submitted orally, an appeal form will be sent to the Provider/Member with the acknowledgement letter. The form must be completed, signed, and returned to DHP.

The appeal request will be reviewed by a Medical Appeal Reviewer of like specialty who did not participate in the original denial. The entire process from receipt of the oral or written appeal to resolution will be completed within 30 calendar days of receipt of the appeal request. The timeframe may be extended up to 14 calendar days if the Member requests an extension, or if DHP shows that there is a need for additional information and how the delay is in the Member's interest. Within 2 (two) calendar days from the decision to delay, DHP will give the Member written notice of the reason for delay if the Member has not requested the delay. Written notice will include the process to file a complaint if the member does not agree with the decision to delay

Appeal for denials of service for not being a covered benefit is a complaint, not an appeal for adverse determination. Member may ask for a State Fair Hearing only, at any time during or after the DHP appeal process. See section below State Fair Hearing Information. Members may ask for an External Medical Review and a State Fair Hearing after DHP mails the appeal decision notice. See information contained in the External Medical Review section of this manual

Members also have a right to request an appeal for denial of payment for services in whole or in part.
Members may be required to pay the cost of Pharmacy/Medication furnished while the appeal is pending, if Pharmacy/Medication were delivered before approval was given.

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

If a Member, as a member of the Health Plan, disagrees with the Health Plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent him/her by writing a letter to the Health Plan telling DHP 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 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 1-877-220-6376 (Nueces) or 1-855-425-3247 (Hidalgo), or send a letter to the Health Plan at:

Driscoll Health Plan
ATTN: State Fair Hearing Coordinator
4525 Ayers St
Corpus Christi, Texas 78415

If the Member ask 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, 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 ask for 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 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 ask for the hearing.

External Medical Review Information

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to DHP by using the address or fax number at the top of the form.;
- Call the MCO at 1-877-220-6376 (Nueces) or 1-855-425-3247 (Hidalgo);
- Email the MCO at DHPSFH@DCHSTX.ORG, or;
- Go in-person to a local HHSC office.

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, 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 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. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw the State Fair Hearing request by contacting the Member's MCO at 1-877-220-6376 (Nueces) or 1-855-425-3247 (Hidalgo).

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 DHP. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete DHP's internal appeals process.

Provider Appeal Process to HHSC

(Related to claim recoupment)

Administrative Claim Appeal – *A request for a review (appeal) of a claim, which has been denied for technical or non-medical reasons.*

Upon notification of claims payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-service or to a different managed care organization on the date of service.

1. **Member eligibility changed to Fee-for-Service on the date of service**
   Provider may appeal claim payment recoupment by submitting the following information to HHSC:
   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
   - **The explanation of benefits (EOB) showing the original payment.** Note: This is ~~also~~ used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by 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 TPI number. 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.
   - **Note:** Label the request **"Expedited Review Request**" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

   Mail Fee-for-Service related appeal request to:

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

   Prepare a new paper claim for each claim that was recoupled, and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

   Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

   HHSC Claims Administrator Contract Management only reviews appeals that are received within eighteen (18) months from the date-of-service. In accordance with the 1 TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. **Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service**
   Providers may appeal claims payment recoupments and denials for services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service.
   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
   - **The explanation of benefits (EOB) showing the original payment. The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment. The letter** must include the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
   - **Documentation must identify** the client name, identification number, DOS, and recoupment amount, and other claims information.
   - **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

   Submit appeals online at: http://driscollhealthplan.com

Mail Fee-for-Service related appeals to:

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

What is a Complaint?

Introduction

DHP has established procedures for the handling and resolution of complaints. DHP Member Services are available to assist those members requiring assistance with the filing of a complaint. This section outlines these processes.

What is a Complaint?

Member Complaint is an expression of dissatisfaction expressed orally or in writing by the member or other individual designated to act on behalf of that member to DHP. Member complaints include but are not limited to the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider/employee or failure to respect the Medicaid member's rights.

Provider Complaint is an expression of dissatisfaction expressed orally or in writing by the provider or other individual designated to act on behalf of that provider, concerning any matter related to DHP other than the provider's dissatisfaction with an adverse benefit determination or appeals regarding claim payments and denials. Provider complaints minimally include any aspect pertain to DHP operations, plan administration, policies/procedures, or claims processing.
Complainant is a member, provider, or other individual designated to act on behalf of the member or provider who files the complaint.

A complaint does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding and reaching satisfaction.

Filing a Member Complaint

A Member or someone acting on behalf of a member ("Complainant") may file a complaint orally or in writing. A Member Advocate is available to assist in the Complaint process, which you can contact by calling the toll-free number.
Submit Complaints as follows:

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2725 **Email:** DHP_QM_Complaints@dchstx.org
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Performance Excellence Team 4525 Ayers Street Corpus Christi, Texas 78415	

Filing a Provider Complaint

A Provider or someone acting on behalf of a provider ("Complainant") may file a complaint orally or in writing. Providers are reminded to retain documentation in regards to all complaints including retention of fax cover pages, email to and from DHP and a log of telephone communications to support their complaint as necessary.
Submit Complaints as follows:

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2725
Email: DHP_QM_Complaints@dchstx.org	**Provider Portal:** www.driscollhealthplan.com
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Performance Excellence Team 4525 Ayers Street Corpus Christi, Texas 78415	

Complaint Process and Resolution

DHP Performance Excellence Team handles all Member and Provider complaints. The processing of a complaint is described as follows:
Initial Contact Complaint - a complaint resolved within one (1) Business Day. No written correspondence is required or provided.
Formal Complaint - a complaint will be resolved within 30 calendar days in which the following timelines are observed:

- Acknowledgement: Upon receipt of the complaint, the Member or Provider will receive an acknowledgement letter within five (5) Business Days.
- Investigation: Review of additional documents submitted will be taken under consideration during the review process.
- Resolution: The Member or Provider will receive a written complaint resolution letter within 30 calendar days.

Members and Providers may submit their complaint orally or in writing.

Provider Dispute Resolution for Administrative Issues

If a provider is not satisfied with the resolution reached during the Complaint Process, the provider may request provider dispute resolution with DHP. The dispute resolution process is for administrative issues only and not for disputes related to credentialing or disciplinary action. The Provider may escalate disputes to HHSC or TDI upon exhausting DHP's internal Complaint Processes. If the issue claims and/or payment related, the provider must complete DHP's internal appeal process prior to escalation to a provider dispute resolution.

- Providers must submit a request for dispute resolution in writing via email, fax or mail no later than 30 calendar days from the complaint resolution letter.
- Acknowledgement: Upon receipt of the dispute resolution notification, the provider will receive an acknowledgement letter within five (5) Business Days.

- Investigation: Review of all documentation submitted during the Complaint resolution process will be forwarded to Executive Leadership for final determination.
- Resolution: The Provider will receive a written Provider Dispute resolution letter within 30 days.

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2725 **Email:** DHP_QM_Complaints@dchstx.org
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Performance Excellence Team 4525 Ayers Street Corpus Christi, Texas 78415	

Filing a Complaint with HHSC

If a member or provider is not satisfied with the resolution provided by DHP and has exhausted the internal appeal and complaint processes, a complaint with the Texas Health and Human Services Commission (HHSC) may be filed. Contact information for HHSC complaint submissions:

DRISCOLL HEALTH PLAN		
Toll Free Customer Service: 1-888-973-0022 **Member Complaint:** 1-866-566-8989 **Provider Complaint:** 1-800-925-9126	**Email:** HPM_Complaints@hhsc.state.tx.us	**Mail:** Texas Health and Human Services Commission MCCO Research and Resolution PO BOX 149030 MC: 0210 Austin, Texas 78414-9030

Provider Disputes Concerning Professional Competence or Conducts

Dispute Resolution

All professional review actions based on reasons related to professional competence or professional conduct that affects or could affect adversely the health or welfare of a patient or patients and that adversely affect a Provider's privileges for a period of longer than 30 days must be reported in accordance with Public Law 99-6660 and the Healthcare Quality Improvement Act of 1986. See, 45 CFR 60.9. The process described herein applies to all contracted Providers, delegated and non-delegated.

In compliance with state and federal regulations, URAC standards, and Driscoll Health Plan (DHP) internal standards, Driscoll Health Plan must report to appropriate monitoring agencies, e.g., the Texas Board of Medical Examiners, Health Integrity Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider's privileges of participation, or denial of acceptance to DHP. In the event that DHP takes an

action to terminate, suspend or limit a Provider's participation status with DHP, Driscoll Health Plan will provide a dispute resolution process as delineated:

Case Identification and Initial Review
A case concerning professional competence or conduct may be identified by any DHP department and a referral for Initial Review initiated by any Director of Driscoll Health Plan, the Quality Management Department, the Chief Medical Officer (CMO), the Medical Director or Credentialing and Peer Review Committee (CPRC), or the Executive Quality Committee (EQC). The initial review will be conducted by, or under the direction of the CMO. The initial review process is not an appeal hearing. An initial review may involve consultation with the Provider, the individual or group making the request or other individuals who may have knowledge of the events, the Special Investigative Unit (SIU)or other Providers as deemed appropriate by the CMO. The initial Review may result in no action or may result grading of the issue from Level 1 – Level 4. In severity. For recommendations of a Level 3 or higher severity, The CMO refers the case to the Credentialing and Peer Review Committee (CPRC) for formal review.

In the case of a serious offense or an imminent risk to member health and safety, an expedited investigation is performed by the CMO, CPRC and ELC with appropriate interventions implemented up to and including immediate suspension and/or termination.

Formal Review
The CPRC convenes in accord with peer review statutes and reviews all available information form the Provider and other sources prior to making a decision. Upon a comprehensive review, the CPRC makes a formal recommendation up to and including suspension or termination. The recommendation is reviewed in conjunction with the Executive Quality Committee (EQC)/Executive Leadership Committee (ELC) for final disposition which may result in a reduction in severity grading of the issues or in actions up to suspension or termination of participation in the Driscoll Health Plan. The provider receives written notice of the adverse action to include the reason for the action, description of desktop review process or. details of the in-person hearing, reference to the evidence/documentation for the action, right to an in person hearing and to have legal counsel. In response to such adverse action, the Provider will be given 30 days to request initiation of an appeal hearing. If the Provider fails to submit a request for an appeal hearing, the adverse action is considered final.

Appeal Hearing (Appeals)
Level 1: The first-level appeal panel consists of at least three contracted Providers who are not otherwise involved in the day-to- day operations of DHP, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier action. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report for the CMO and EQC/ELC for implementation of their recommendation. If the appeal panel's findings result in upholding the limitation, suspension or termination, the Provider will be notified of the appeal panel's findings and given 10 business days to request a second appeal hearing for reconsideration of the action.

Level 2: The second-level appeal panel will consist of at least three contracted Providers who are not otherwise involved in the day-to-day operations of DHP, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier actions. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report for the CMO and EQC/ELC for implementation of their recommendation. The Provider will be notified of the second appeal panel's findings, which are considered final.

Reapplication Subsequent to Adverse Action
A Provider who has had an adverse action taken against him/her may not reapply for network participation for a period of two year (24 months) unless specified otherwise in the terms of the adverse action.

SECTION E

STAR/STAR Kids Medicaid Member Rights and Responsibilities

Member Rights

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

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. 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 health plan or provider in a reasonably easy manner. That includes the right to:

    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that health plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment an actively participate in treatment decisions. That includes the right to:

    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and receive information about how that process works.
    e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

    a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.

c. Be able to get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know the doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities

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

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

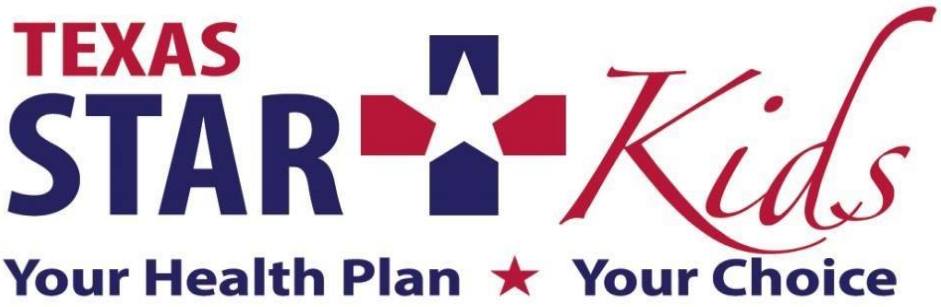
3. You must share information about your health status with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions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

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

d. Treat providers and staff with respect.
e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT Service with SafeRide Health:

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
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 appointments.
6. You must only use NEMT Services to travel to and from your medical appointment.


TEXAS
STAR
Kids
Your Health Plan ★ Your Choice

SECTION A

Population Health

STAR Kids Benefits are governed by the DHP contract with the Health and Human Services Commission (HHSC) and include medical, vision, behavioral health, pharmacy and long term services and support (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP.

Definitions

1915(i) Home and Community Based Services - Adult Mental Health (HCBS-AMH)
Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a statewide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each individual's needs, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long-term recovery from mental illness.

Community Living Assistance and Support Services (CLASS) Waiver Program
The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program
The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost- effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Dual-Eligible
Medicaid recipients who are also eligible for Medicare.

Home and Community-based Services (HCS) Waiver Program
The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Long-Term Services and Supports (LTSS)
LTSS means assistance with daily health care and living needs for individuals with a long- lasting illness or disability.

Medical Dependent Children Program (MDCP) Waiver Program
The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

Texas Home Living (TxHmL) Waiver Program
The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

Youth Empowerment Services (YES) Waiver Program
The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

SECTION B

Service Coordination

Service Coordination

Service Coordination is a person-centered approach by a Service Coordinator designed to enhance services provided. Service Coordinators assist Members with initial and ongoing assistance identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance the member's well-being, independence, integration in the community, and potential for productivity.

All Home and Community Support Services Agency (HCSSSA) providers, adult day care providers, and residential care facility providers must notify DHP if a Member experiences any of the following:

- a Significant change in the Members physical or mental condition or environment;
- hospitalization;
- an emergency room visit; or
- two (2) or more missed appointments.

The designated Service Coordinator will perform an assessment or reassessment to identify any newly functional or medical needs the Member may have developed.

Member Protections

Network Providers must inform the DHP of any reports of abuse, neglect, or exploitation made regarding a member. This includes provider self – reports made by others that the provider becomes aware of.

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.
The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about External Medical Reviews, State Fair Hearings and continuing services during the appeal process.

When should Members call the escalation help line?

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

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

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

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

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

Electronic Visit Verification (EVV)
General Information about EVV

1. What is EVV?

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

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

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

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

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

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification. Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

- EVV Service Bill Codes Table - Version 10.0 (Excel)
- EVV Service Bill Codes Table - Version 10.0 (PDF)

4. Who must use EVV?

The following must use EVV:

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

EVV SYSTEMS

5. Do Providers and FMSAs have a choice of EVV Systems?

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.
  TMHP EVV Vendors
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:

- Is purchased or developed by a Provider or an FMSA.
- Is used to exchange EVV information with HHSC or an MCO; and
- Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

TMHP Proprietary System Information

6. Does a CDS Employer have a choice of EVV Systems?

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

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

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.
- TMHP State Approved Vendors and Contact Information 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.
  EVV Proprietary System Onboarding Process

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

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor.
  TMHP State Approved Vendors and Contact Information
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer to Question #18; 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.

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

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

10. Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

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

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

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

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

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

EVV SERVICE AUTHORIZATIONS

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

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

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO;
  - Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; 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

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

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

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

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

(3) Alternative device

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

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

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

EVV VISIT MAINTENANCE

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

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.
Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

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

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

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

EVV Reason Codes
HHSC EVV Website

EVV TRAINING

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

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHSC or the MCO.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.

- Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
  - EVV System training provided by EVV vendor or EVV PSO; and
  - EVV Policy training provided by HHSC, the MCO or FMSA.
- Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
  - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
  - EVV policy training provided by HHSC, the MCO or FMSA.

- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

For Driscoll Health Plan EVV training information contact EVVQUESTIONS@DCHSTX.ORG

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

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

For Driscoll Health Plan EVV Compliance Review information contact EVVQUESTIONS@DCHSTX.ORG

EVV CLAIMS

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

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

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

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.
Information on Claims' Submission and Process for Corrected/Adjusted Claims

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

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

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

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

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.

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

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

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

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

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

EVV claim match codes viewable in the EVV Portal are:

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

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

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

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

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

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

Accessing the EVV Portal Job Aid for Providers and FMSAs

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?
Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service**.**

SIU Surveillance Plan

The plan outlined below would be effective from May 1, 2020 in order to take proactive steps in identifying cases related to Fraud, Waste and Abuse. This plan is a part of Special Investigation Unit of Driscoll Health Plan.

Random 50 calls per month will be made to the members to verify that they are receiving the services as authorized. These calls will be spread across the different services that DHP authorized their member for as well the different service areas where DHP serves. Twenty percent of the member called per month will belong to those who use EVV services to verify their services. All the DHP members will be the part of random selection. If the member does not answer the call, the next member in the list is contacted making overall total 50 calls per month. No given member will be contacted again for the next 2 years unless required.

When DHP representative makes a call to a member or their LAR, member will be asked some questions after conforming their identity. These questions are but not limited to the following:
1) What type of services are you currently receiving?
2) Who is your provider and attendant who provide these services?
3) Do you use EVV if yes what type of verification method you or your attendant is using?
4) Is there any concerns or feedback you would like to share?

The member response to the calls made by the DHP representative will be noted and documented in secure folder. Any member response which raises red flags like member receiving services different from what they are authorized or member not receiving any services yet showing claims for those members, etc. will be reported to Special Investigation Unit (SIU). Within 48 hours of receiving such cases, SIU representative will open investigation against attendant, provider agency or member as reported. Actions will be taken against the attendant/provider agency/member on case-to-case basis. All the communications and results of SIU investigation will be documented.

"Effective September 1, 2020, Texas Health and Human Services (HHS) mandated Managed Care Organizations (MCOs) to require Personal Care Services (PCS) agencies to conduct unannounced visits to validate that services for Medicaid (STAR Health and STAR Kids) members were rendered and billed correctly.

To comply with this new MCO contractual requirement, Driscoll Health Plan will conduct audits of randomly selected PCS agencies to validate agency compliance with program integrity policies and procedures. Driscoll will also conduct a representative sampling of supervisory oversight during PCS visits in the member's home.

Upon receipt of a Driscoll's PCS oversight audit request, all requested documentation should be submitted within the timeframe specified in the request."

The Role of the Service Coordinator

Service Coordination Integrated Pods (SCIP) are person-centered team support networks designed to enhance services provided by the Service Coordinator. DHP provides SCIP which may include a Registered Nurse (Service Coordinator 1-SC1), Social Worker (Service Coordinator 2- SC2), a non-clinical staff member (Service Coordinator 3-SC3), or other licensed or unlicensed persons as necessary to address needs identified in the Members' Individual Service Plan (ISP). SCIPs are led by named Service Coordinator (SC1). SCIP's must have access to individuals with expertise or access to identified subject matter experts in the following areas:

- Behavioral health
- Co-occurring behavioral health conditions and IDD
- Medically complex conditions
- Substance abuse

- Local resources *(e.g., basic needs like housing, food, utility assistance)* – ***M*CO's** are encouraged to use certified Community Health Workers to support individuals in local areas
- Pediatrics
- Long Term Services and Supports (LTSS), including HCBS Waiver programs
- Durable Medical Equipment (DME)
- End of life/advanced illness
- Curative treatment or palliative care
- Acute care
- Preventive care
- Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- Pharmacology
- Nutrition
- Consumer Directed Services
- Texas Promoting Independence strategies such as diversion and relocation
- Person-Centered Planning
- Family Partners
- Peer Supports
- Positive behavior support
- Assistive Technology including augmentative communication, seating, and positioning
- Supported employment
- Permanency planning
- School transition

A Member's interaction with a SCIP must be tied to the level and frequency of coordination desired by the Member and the Member's Legal Authorized Representative (LAR) and appropriate to the Member's needs. The named Service Coordinator (SC1) responsible for leading the SCIP must work with the team to ensure the team addresses objectives identified in the Member's ISP.

Members/LARs can access a member's designated Services Coordinator by contacting the Service Coordination Department **1-844-508-4673** (Nueces SA) or **1-844-508-4675** (Hidalgo SA).

The Screening and Assessment Instrument (SAI)

Service Coordinators perform a Screening and Assessment Instrument (SAI) on all new STAR Kids members. An SAI is a standardized care needs assessment that is comprehensive, holistic, consumer directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living.

The STAR Kids SAI Process will:

- help identify the complexity and intensity of an individual's physical, medical, mental, social, developmental, and behavioral needs;
- help identify member preferences and goals;
- identify trends and provide insight on the utilization of services and quality of care;
- inform the development of Individual Service Plans (ISP), which must include preferences, goals, service needs, and plans for obtaining service; and
- help ensure consistency and equity for all STAR Kids members.

The SAI will be used to determine priority based on urgency identified through the initial telephonic screening and claims data.

- Priority 1: those who become STAR Kids Members after the Operational Start Date and request immediate services.
- Priority 2: those with the most complex medical or behavioral health needs or with an urgent need for services or service coordination.

- Priority 3: those with needs that are less variable and who are currently receiving the services they require to remain stable.

The SAI will consist of four modules; Core Module; Personal Care Assessment Module (PCAM); Nursing Care Assessment Module (NCAM); and the MDCP Module. The Core Module will determine Member preferences; trigger for the PCAM, NCAM, or both; identify follow-up assessment needs; help determine Service Coordination Level; and inform the development of the Member's ISP. The Personal Care Assessment Module (PCAM) is used to assess Member's need for Functionally Necessary Personal Care Services. The Nursing Care Assessment Module (NCAM) is a module that captures information on diagnosis and physical condition in order to determine Nursing Service needs. MDCP module identifies medical information for HHSC or its designee for Medical Necessity determinations.

Level 1 Members include the following Member types:
- MDCP STAR Kids Members
- Members with Complex Needs or a history of developmental or behavioral health issues *(multiple outpatient visits, hospitalization, or institutionalization within the past year)*
- Members with SED or SPMI
- Members at risk for institutionalization

Level 2 Members include the following Member types:
- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services, including PDN and PPECC.
- Members the MCO believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional MCO findings
- Members with a history of substance use disorder *(multiple outpatient visits, hospitalization, or institutionalization within the past year)*
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

Level 3 Members include those who do not qualify as Level 1 or Level 2. All Level 1 or Level 2 Members will have an assigned Service Coordinator. DHP will provide access to service coordination services to all Level 3 Members.

Service Coordinator Services

Service Coordination provides the Member with initial and ongoing assistance by identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity. Members are assisted in maintaining the highest level of functioning possible in the least restrictive setting, and avoiding ER visits, hospitalizations, and institutionalization.

Service coordination:
- provides a holistic evaluation of the Member's individual dynamics, needs, and preferences;
- educates and helps provide health-related information to the Member, the Member's LAR, and others in the Member's Support Network;
- helps to identify the Member's physical, behavioral, functional, and psychosocial needs;
- engages the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP);
- connects the Member to Covered and non-covered services necessary to meet the Member's identified needs;
- monitors to ensure the Member's access to covered services is timely and appropriate;
- coordinates Covered and non-Covered Services; and
- intervenes on behalf of the Member if approved by the Member.

All medically necessary Covered Services covered under the traditional, fee-for-service Medicaid programs are provided to all members who are enrolled in Driscoll Health Plan on and after the operational start date.

Covered Services are subject to change due to changes in federal and state law; changes in Medicaid Program policy; and changes in medical practice, clinical protocols, or technology. Services are coordinated and authorized without regard to any previous coverage, pre-existing conditions, prior diagnoses, receipt of any prior health care services, health status, confinement in a health care facility, or for any other reason. Acute care services and service coordination are provided to members residing in a nursing facility or an ICF/IDD if the services are not provided as part of the daily rate of those facilities. Services are coordinated with facility-based LTSS providers providing non-capitated services and will include acute care and service coordination to those members who are enrolled in an HCBS Waiver not integrated into STAR Kids. Community- based Long Term Services and Supports (LTSS) are provided for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility.

Adult Transition Planning

STAR Kids Only

The MCO will help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns 15 years old. The MCO must provide transition-planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division. Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the MCO must inform the Member and the Member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the Member with Self-Management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult health care providers.

Transition Plan

Transition Coordinators are dedicated to assisting Members and Service Coordinators with transition planning for adulthood. They counsel and educate Members and others in their support network about considerations and resources for transitioning out of STAR Kids.

Teens and young adult Members receive early and comprehensive transition planning beginning when they turn fifteen (15) years old to help prepare them for service and benefit changes that will occur following their 21st birthday.

Transition includes the development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service. Prior to the age of 10, the

Member and the Member's LAR are provided information regarding LTSS programs offered through the Department of Aging and Disability Services (DADS). Assistance in completing the information needed to apply. DADS LTSS programs include Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS).

Part of the transition process includes coordinating with DARS to help identify future employment and employment training opportunities and coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals. Health and wellness education are provided to assist the Member with Self-Management. Barriers and opportunities and identified and resources are provided to assist the Member in their transition to adulthood including assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday. Members are provided assistance in identifying adult health care providers.

Service Coordination for Level 1, 2 and 3 Members

There are three tiers of Service Coordination and Members are assigned to the appropriate tier based on their level of medical necessity.

The members' health, well-being, and ability to live safely in their community are goals that the Service Coordinators (SCs) focus on while performing assessments to evaluate the members' physical, behavioral, social, educational, and medical needs. The team uses evidence-based best practices, person-centered planning, and cultural competency to ensure that the members receive the best care possible. The members' Primary Care Physicians (PCPs), LARs, and family members are included in the Service Coordination process and input into the member's plan of care is encouraged.

Individual Service Plan (ISP)

DHP will create and regularly update a comprehensive Person Centered ISP for each STAR Kids Member. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences. The ISP must be used to communicate and help align expectations between the Member, their LAR, the MCO and key service providers. The ISP may also be used by the MCO and HHSC to measure Member outcomes over time.

All ISPs must account for the following information:

1. A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process;
2. Covered Services currently received;
3. Covered Services not currently received, but that the Member might benefit from;
4. A description of non-covered services that could benefit the Member;
5. Member and family goals and service preferences;
6. Natural strengths and supports of the Member including helpful family members, community supports, or special capabilities of the Member;
7. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key service providers, the Member's Health Home, the MCO, and the Member's school (if applicable);
8. A plan for coordinating and integrating care between Providers and Covered and Non-Covered Services;
9. Short and long-term goals for the Member's health and well-being;
10. If applicable, services provided to the Member through YES, TxHmL, DBMD, HCS, CLASS, or third-party resources, and the sources or providers of those services;
11. Plans specifically related to transitioning to adulthood for Members age 15 and older; and
12. Any additional information to describe strategies to meet service objectives and Member goals.

The ISP must be informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO. To the extent possible and applicable, the ISP must also account for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

Discharge Planning

Discharge planning begins before the Member's discharge from a Hospital or other care or treatment facility, including inpatient psychiatric facilities.

The Service Coordinator will work with the Member's PCP, the Hospital or inpatient psychiatric facility discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge in order to meet the Member's needs in the community and establish appropriate service authorizations.

Upon receipt of notice of a Member's discharge from an inpatient facility (psychiatric or acute), Service Coordinators must contract the Member within one Business Day. When long-term care is needed, the Member's discharge plan includes arrangements for receiving Community-Based Services as appropriate.

Long-Term Services and Supports Provider Responsibilities

Long Term Services and Support Services (LTSS)

LTSS means assistance with daily health care and living needs for individuals with a long lasting illness or disability.

The Long Term Services and Support (LTSS) provider delivers medically necessary and functional necessary services to the STAR Kids (SK) Medically Dependent Children's Program (MDCP) Members. Services include Personal Care Services, Private Duty Nursing, Adaptive Aides, Minor Home Modifications, CFC benefits (Habilitation, Emergency Response Service, and Support management), Respite, Employment services (Supported Employment, Employment Assistance), Financial Management Services, Flexible Family Support Services, and Transition Assistance Services. The LTSS provider obtains prior authorization and coordinates delivery of services in collaboration with the Member, Member's PCP, and DHP's Service Coordinator.

Responsibility to Contact Health Plan to verify Member Eligibility or Authorization for Services

LTSS providers provide Community-based LTSS to STAR Kids MCDP members with complex medical needs as a cost-effective alternative to living in a Nursing Facility. LTSS providers have the responsibility of, but not limited to:

- Contacting DHP for Member Eligibility and authorization of services.
- Notifying DHP of any change on member's condition or eligibility.
- Providing services based on contract agreement with DHP.
- Providing those services in which they are licensed to deliver.

DHP requires that LTSS Providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process), and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS Provider fails to comply with these requirements, HHSC will notify DHP to hold payments to the LTSS provider until HHSC instructs DHP to release the payments.

LTSS providers must prior authorize LTSS by submitting prior authorization requests to DHP's Service Coordination Department at **1-844-508-4673** (Nueces SA), and **1-844-508-4675** (Hidalgo SA).

Continuity of Care

DHP ensures that the health care of newly enrolled Members is not disrupted, compromised, or interrupted. DHP takes special care to provide continuity in the care of enrolled Members who are Medically Fragile and those whose physical or

behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted. Steps taken by DHP to assure continuity of care are, but not limited to:

- Ensure all necessary authorizations are in place
- Allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the Provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.
- Pay a Member's existing Out-of-Network Providers for Medically Necessary and Functionally Necessary Covered Services and equipment and supplies until the Member's records, clinical information, and care can be transferred to a Network Provider, or until the Member is no longer enrolled in that MCO, whichever is shorter.

To ensure Continuity of Care, when Member transfers from another MCO, the SC will attempt to contact the Member's prior MCO and request information regarding the Member's needs, current Medical Necessity determinations, authorized care, and treatment plans.

Upon notification from a Member or Provider of the existence of a Prior Authorization, DHP will ensure Members receiving services through a Prior Authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

a. 90 calendar days after the transition to a new MCO,
b. Until the end of the current authorization period, or
c. Until the MCO has appropriately evaluated and administered the STAR Kids SAI and issued or denied a new authorization.

Medicaid/Medicare Coordination
The DHP will supplement Medicare coverage for STAR Kids Members by providing services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program. There are three categories of Medicaid wrap-around services:

- Medicaid Only Services (i.e., services that do not have a corresponding Medicare service);
- Medicare Services that become a Medicaid expense due to a Medicare benefit limitation; and
- Medicare Services that become a Medicaid expense due to coinsurance (True Cross-over Claims).

Coordination of benefits for Dual Eligible as applicable
The STAR Kids program is intended to coordinate program services for Dual Eligible recipients. DHP will provide all medically necessary Covered Services that are not covered by Medicare to Dual Eligible Members. DHP will also reimburse Medicare providers for the Medicare cost- sharing obligations that HHSC would otherwise be required to pay on behalf of qualified STAR Kids Dual Eligible Members. Under the Agreement, DHP will be required to provide all enrolled STAR Kids Dual Eligible Members with the coordinated care and other services.

Notification to MCO of change in Members physical condition or eligibility
LTSS providers have the responsibility to notify DHP of any change in Member's physical condition and/or eligibility.

Employment Assistance Responsibilities
Providers must develop and update quarterly a plan for delivering employment assistance services.

- Providers must assist STAR Kids Member to obtain competitive employment.

Supported Employment Responsibilities
Providers must develop and update quarterly a plan for delivering supported employment services

- Providers must assist STAR Kids Member to retain competitive employment.

Long-Term Services and Supports Benefits

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
Services Available through DHP to STAR Kids Members Enrolled in the Medically Dependent Children Program (MDCP) Waiver				
Adaptive Aids (AA)	A device that is needed to treat, rehabilitate, prevent or compensate for a condition that results in a disability or a loss of function and helps a person perform the activities of daily living or control the environment. Adaptive Aids services include vehicle lifts and vehicle modifications to accommodate disabilities.	No	No	$4,000 per IPC Year
Employment Services: **Employment Assistance (EA)**	Assistance provided to an individual to help the individual find and maintain paid employment in the community. Services include: 1. Identifying job preferences, job skills, and work setting requirements. 2. Conducting training on identified needs. 3. Locating and contacting prospective employers. 4. Negotiating individual's employment. 5. Transporting individual to locate employment. 6. Participating in service planning team meetings.	No	No	Up to 180 days of service
Employment Services: **Supported Employment (SE)**	Supported Employment means assistance provided, in order to sustain paid employment, to an individual who, because of disability, requires intensive, ongoing support to be competitively employed self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment includes adaptations, supervision, and training related to an individual's diagnosis.	No	No	Dictated by LTSS budget limits
Financial Management Services (FMS)	Financial Management Services (FMS) are professional services that enable a waiver individual to employ staff under the Consumer Directed Services (CDS) option:	Yes FMS applies only when a family has elected to use their CDS option for services where the	No	Dictated by LTSS budget limits

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
	1. Hiring and firing assistance 2. Background checking – vetting 3. Training 4. Payroll and tax services to employed individuals If a STAR Kids family elects to receive services under the CDS, they are required to engage a Financial Management Services Agency (FMSA) that is contracted with DHP.	CDS option is available.		
Flexible Family Support Services (FFSS)	FFSS provides assistance to families of children with disabilities at times when the primary caregiver is working, training for work, or in school. The services include: (1) **Activities of daily living (ADL) services:** Activities essential to daily self-care, including bathing, dressing, grooming, routine hair and skin care, feeding, exercising, toileting, transfer and ambulation, positioning, range of motion, and assistance with self- administered medications. (2) **Instrumental activities of daily living (IADL) services**: Activities such as doing laundry, performing light housework, or fixing meals. (3) **Adjunct support services:** Direct care services needed because of an individual's disability that help an individual: (A) participate in child care, post-secondary education, or independent living; or (B) support an individual's move to an independent living situation. (4) **Personal attendant/care services (PAS or PCS)**: An employee of a provider or of an individual who has selected the consumer-directed services option who provides direct care to the individual. **Basic child care**: Watchful attention and supervision of an individual while the individual's primary	Yes **NOTE**: ***Adjunct Services are a CDS-eligible*** service so long as the services to be performed are not "delegated services". A **Delegated Service** is defined as: A service that a practitioner or RN delegates in accordance with state law. In general, the Texas Board of Nursing defines nurse delegation as authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task. In brief, the Texas Occupations Code indicates a physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate.	Yes, if provided through a DHP contracted HCSSA. Optional, if the family accesses these services under the CDS option.	Dictated by LTSS budget limits

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
	caregiver is at work, in job training, or at school.			
Minor Home Modification (MHM)	A physical change to an individual's residence that is needed to prevent institutionalization or to support the most integrated setting for a person to remain in the community. Minor home modifications include: 1. Modifications of existing bathroom, e.g. grab bars 2. Widening existing doorways Adding wheelchair or ambulatory access ramps.	No **Or under the CDS Option**	No	$7,500 per lifetime (includes up to $150 for code inspection services) **PLUS** Up to $300 per year for repairs of modifications provided under the waiver.
Respite: **In-Home**	Direct care to an individual to provide a caregiver temporary relief from caregiving activities when the caregiver would usually perform such activities. **Primary Caregiver** - A person who is legally responsible for an individual's routine daily care, provision of food, shelter, clothing, health care, education, nurturing, and supervision; and provides daily, uncompensated care for the individual. For MDCP, this benefit is comprised of Nursing Services and Personal Care.	Yes **In-the-Home**: Many respite units of service are delivered in the home of the individual by a **HCSSA** provider (RN, LVN, Attendant with or without delegation) ***or under the CDS option.***	Yes	Dictated by LTSS budget limits
Respite: Out-of-Home	Direct care to an individual to provide a caregiver temporary relief from caregiving activities when the caregiver would usually perform such activities. Primary caregiver - A person who is legally responsible for an individual's routine daily care, provision of food, shelter, clothing, health care, education, nurturing, and supervision; and provides daily, uncompensated care for the individual. For MDCP, this benefit is comprised of Nursing Services and Personal Care.	No **Out-of-Home**: Respite services can also be delivered out of the home in the community on either an inpatient, residential, ambulatory, or community basis. The ***CDS option is not available*** for out-of-home respite. **Inpatient**: 1. Nursing Facility 2. Hospital **Residential**: 1. Special Care Facility 2. Host Family	No	Facility-based respite limited to 29 days per IPC year.

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
		Ambulatory: 1. Day Care Centers 2. Licensed Child Care Facility **Community**: Community Camps		
Transition Assistance Services (TAS)	**One-time service** that pays for non-recurring, set-up expenses for essential items and services that allow people to transition from a nursing home to the community. TAS are not available to residents moving from a nursing facility for the following waiver services: 1. Assisted living services 2. Adult foster care services 3. Support family services 4. 24-hour resident habilitation 5. Family surrogate services TAS may include, but is not limited to, payment or purchases of: 1. Apartment or house security deposit. 2. Utility fees to starting service. 3. Essential furnishing for an apartment or home, including: table and chairs, window blinds, dishes and eating utensils, and food preparation items. 4. Moving expenses required to move into and occupy an apartment or home, services to ensure safety and health of individual, e.g. pest eradication, allergen control, one-time cleaning before occupancy.	No	No	$2,500 per lifetime
Day Activity and Health Services (DAHS)	Licensed day activity and health services (DAHS) facilities provide daytime services to people who live in the community as an alternative to living in a nursing home or other institution. Services, which usually are provided Monday - Friday, address physical, mental, medical and social needs. Sometimes, this is called adult day care or adult day services Services include: • Noon meal and snacks • Nursing and personal care • Physical rehabilitation • Social, educational and recreational activities • Transportation	No	No	No Limit

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
	Client must: • be at least 18. • have a functional disability related to medical diagnosis. • have a medical diagnosis and physician's order requiring care or supervision. • need help with one or more personal care tasks. • meet these eligibility criteria: • must be a Medicaid recipient to get Title XIX services; and • your income and resources may not exceed specified limits to get Title XX services.			
Community First Choice (CFC) Services Available to any STAR Kids Member Meeting Criteria **(CFC Providers include: licensed home and community support service agencies, certified HCS providers, licensed ERS agencies, qualified FMSA's and CHS provider hired by member families)**				
Personal Attendant Services (PAS)	Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision or cueing. CFC personal assistance services provide assistance to a member in performing the ADLs and IADLs based on the person- centered service plan. PAS includes: • non-skilled assistance with ADLs and IADLs • household chores • escort services • assistance with health-related tasks, including delegated nursing, health maintenance activities, and extension of therapy.	Yes	Yes	Due to availability of unlimited PCS services for qualified individuals, this service may not be frequently used.
Emergency Response System (ERS)	ERS alarm services installed in the home with push button control to call for emergency assistance. • A service for members who would otherwise require extensive routine supervision and who: o Live alone o Are alone for significant parts of the day o Do not have regular caregivers for extended periods of time	No	No	All medically necessary

Benefit	Description	CDS Option Available?	EVV Required?	Limitations
Habilitation	Community and ambulatory facility-based services to help members acquire, maintain, and enhance skills to accomplish ADLs, IADLs, and health-related tasks. Habilitation services target: • Self-care • Personal Hygiene • Household tasks • Mobility • Money management • Community integration • Use of adaptive equipment • Restoring or compensating for reduced cognitive skills • Personal decision-making • Interpersonal communication • Socialization • Leisure activity participation • Self-administration of medication • Use of natural supports	No	No	All medically necessary
Support Management Services	Provides voluntary training on selecting, managing, and dismissing attendants. This service is available to all STAR Kids members who qualify for CFC services regardless of whether they are obtaining the services under CDS, the Agency Option (AO), or the Shared Risk Option (SRO).	Yes	No	All medically necessary
Other LTSS-like Services Available to All STAR Kids Members (in or out of waiver programs)				
Private Duty Nursing (PDN)	In-home private duty nursing services provided by registered nurses.	No	No	All medically necessary
Personal Care Services (PCS)	In-home attendant to assist with ADL's and IADL's.	No	Yes	All medically necessary

At a minimum, the participating MCO must provide a benefit package to Members that includes Fee- for-Services (FFS) acute care and LTSS services currently covered under the Texas Medicaid program. MDCP services are covered for individuals who qualify for and are approved to receive MDCP. See Texas Provider Procedure Manual (TMPPM) for listings of limitations and exclusions.

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

At the time a STAR Kids Member is approved for LTSS, the DHP must ensure that the Member is informed orally and in the Member Handbook of the processes for reporting allegations of Abuse, Neglect, or Exploitation. The toll-free numbers for DADS and DFPS must be provided.

Population Health Services (PHS) Service Coordination

Population health management is the practice that "strives to address health needs at all points along the continuum of health and well-being, through participation, engagement with, and targeted interventions for the population" (CMSA, 2019).

DHP Population Health Services (PHS) support the following Medicaid Managed Care programs in the Nueces and Hidalgo Delivery Areas:

- STAR/STAR AAPCA – Nueces and Hidalgo
- CHIP – Nueces Only
- STAR Kids / STAR Kids AAPCA – Nueces and Hidalgo

PHS focus is on member screening, identification, selection, assessment, development of service plan, implementation and coordination of the plan, evaluation of the plan, and follow-up. Our integrated population management program factors in quality, safety, access, cost, and evaluating resources correlating to the needs and preferences of the person.

Members with identified needs are assessed for Service Coordination enrollment. Members with needs may be identified through a variety of means to include, but not limited to staff, claims, hospital census, and direct referral from provider, self-referral or health risk assessment.

PHS supports the person, family, and provider by:

- Connect the member to the Primary Care Provider (PCP) and develop service plan interventions in partnership
- Establish service plan objectives, monitor outcomes and review the service plan as necessary
- Refer and assist the member in ensuring timely access to providers
- Providing a person-centered holistic approach across physical, behavioral, social and system domains (Social Determinants of Health)
- Promoting person-centered self-management skills
- Supporting the delivery of effective, efficient quality clinical care
- Decreasing Medical and Behavioral health preventable admissions and preventable visits
- Coordinating provider involvement by enhanced technology access to service coordination practices
- Delivering health education supporting preventive and chronic care compliance
- Managing complex health conditions through use of evidence-based guidelines
- Assess the member's satisfaction with complex Service Coordination
- Coordinating with hospital systems for impactful discharge planning and supporting transition of care from hospital to home
- Measure the program's effectiveness

Programs for Service Coordination

Our programs collaborate with members via telephonic, face-to-face, text messaging, telehealth, and community-based resource programs and education classes.

The following programs are a part of Service Coordination:

- Asthma
- Behavioral Health
- Diabetes
- Members with Special Health Care Needs (MSHCN)
- High-risk pregnancy

Disease Management

Disease Management Programs are designed to prevent exacerbation of symptoms that might result in hospitalization. Disease management helps Members manage illness more effectively as to improve their quality of life. PHS Disease Management programs are under the supervision of the Medical Director.

Currently, DHP offers PHS Disease Management Programs in Asthma and Diabetes. If you encounter a Member that you feel would benefit from one of these programs designed to increase patient education regarding their health and or disease process, nutrition, medication and compliance issues, or community-based resources available to them, please refer a member for enrollment in DHP Population Health Services Service Coordination for CHIP, STAR or STAR Kids Service Coordination Department at 1-844- 508-4673 (Nueces) or 1-844-508-4675 (Hidalgo), Monday through Friday, 8 a.m. to 5 p.m. (CST) or submit a Service Coordination referral via Driscoll's Secure Provider Portal.

We will be available to help in facilitating the physician-based treatment plan in a collaborative effort with the Member's various health care providers to help in improving or maintaining the wellbeing of the Member. In addition, DHP supports service coordination for those with catastrophic and/or other complex medical needs.

Reference:
Case Management Society of America (CMSA). 2019. Retrieved from https://cmsa.org/

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A client has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (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 client may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are not provided.) The combined total hours between PDN and PPECC services 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 client's medical needs. IN accordance with 1 Tex. Admin Code § 363.209(c) (3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hour are medically necessary. ***AUTHORIZATION REQUIRED***

Children's Health Insurance Program (CHIP)

SECTION A

Eligibility of Members

HHSC Determines Eligibility

The Texas Health and Human Services Commission (HHSC) is responsible for determining CHIP eligibility. For information regarding eligibility, contact HHSC CHIP hotline at **1-800-647-6558**.

For other help, call **DHP Member Services at 1-877-451-5598**.

Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure that all required documentation and forms are gathered.

Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on the available health plants in each area. The enrollment broker received each Member's plan and PCP selection documentation and notifies health plans of their new members.

General Eligibility for CHIP

Currently, children under age 19 and whose family's income is below 206% of the federal poverty level (FPL) are eligible to enroll in the CHIP program if they do not qualify for STAR/Medicaid coverage. An applicant or family member is potentially Medicaid or CHIP eligible and should be referred to the local Medicaid agency or 2-1-1 for a formal Medicaid/CHIP eligibility determination if any of the following is true:

a. The applicant is a pregnant woman who is a citizen or eligible alien with family income at or below 198% of FPL. (Medicaid)
b. The applicant is a child under age 1 who is a citizen or eligible alien with family income at or below 203% of FPL. (Medicaid)
c. The applicant is a child age 1 through 5 who is a citizen or eligible alien with family income at or below 149% of FPL. (Medicaid)
d. The applicant is a child age 6 through 18 who is a citizen or eligible alien with family income at or below 138% of FPL. (Medicaid)
e. The applicant is a child under age 19 and whose family's income is at or below 206% of (FPL) (CHIP)

The CHIP enrollment period is a 12-month period. Prior to the end of the eligibility period, Members are sent re-enrollment packets to complete and return to the enrollment broker. Determination of coverage is made by the State Administrative Services Contractor. Members should complete the necessary forms and return as soon as possible to the enrollment broker to prevent lapses in coverage. Physicians should encourage Members to re-enroll.

Children of families with Group Health Insurance or Medicaid coverage for the children are NOT eligible for the CHIP program.

Pregnant Members are no longer automatically disenrolled from CHIP and placed in Medicaid. Health plans notify the enrollment broker when a CHIP Member is pregnant and a re- determination for Medicaid eligibility occurs. This process can take up to an average of 60 days.

There is not spell of illness limitation for CHIP Members. For up to date CHIP eligibility requirements please refer to **http://www.chipmedicaid.com**.

A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

A CHIP Perinate mother in a family with an income at or below 185% of the FPL may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 185% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate Newborn" if born to a family with an income above 185% to 200% FPL and the birth is reported to HHSC's enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months of 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 health plan.

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member's enrollment period, or (2) the end of the traditional CHIP 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 perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

Verification of Eligibility

To confirm member eligibility Providers may contact DHP at **1-877-451-5598**, or visit the DHP website at ***www.driscollhealthplan.com***. Currently, Members are enrolled for a twelve (12) month period, or as stated above for CHIP Perinate Newborn members.

DHP issues a CHIP Member ID card. An example of this card is included in **Appendix**.

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 Medicaid eligibility and DHP enrollment for the date of service prior to services being rendered. There are two ways to do this:

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

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

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

Span of Eligibility (Members' Right to Change Health Plans)

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

- For any reason within the first 90 days of enrollment in CHIP and once thereafter;
- For cause at any time;
- If the client moves to a different service delivery area; and
- During the annual re-enrollment period *(Re-enrollment period is not applicable to CHIP Perinate members)*.

Requests are forwarded to HHSC, who makes the final determination. For more information, contact the CHIP Helpline at **1-800-647-6558.**

Disenrollment from Health Plan

Disenrollment may occur if a Member loses CHIP eligibility. A CHIP Member can lose CHIP eligibility for the following reasons:

- "Aging-out" when the Member turns 19 years of age
- Failure to re-enroll by the end of the 12-month coverage period
- Change in health insurance status, i.e., a Member enrolls in an employer sponsored health plan
- Death of a Member
- Member permanently moves out of the state
- Failure to drop current insurance if child was determined to be CHIP eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income
- Child's parent or authorized representative requests, in writing, the voluntary disenrollment of a child
- For CHIP Perinate Member, once the member delivers the baby, coverage ends for the mother, but continues for the newborn.

Providers may not request that a Member be disenrolled from the health plan, and from managed care, without good cause. The Provider cannot make this request due to retaliatory action against the Member.

DHP can also request a Member be disenrolled from DHP for the following reasons:

- Fraud or intentional material misrepresentation
- Fraud in the use of services or facilities
- Misconduct that is detrimental to safe plan operations and the delivery of services
- Failure to establish a satisfactory patient/physician or patient/provider relationship
- Child no longer lives or resides in the service area

DHP cannot request a disenrollment based on adverse change in the Member's health status or utilization of services that are medically necessary for the treatment of a Member's condition.

All requests are forwarded to HHSC, who makes the final decision.

Pregnancy Notification Requirements

If a provider identifies a CHIP Member as being pregnant, he/she should notify the Case & Disease Management Department **immediately** to ensure that the Member receives the highest level of coverage available. Most pregnant CHIP Members, up to the age of nineteen (19), and their newborns, up to the age of one (1) year, will qualify for Medicaid. Since the Medicaid Program now provides a much more comprehensive scope of services for both the pregnant Member and their newborn, it is in the best interest of the pregnant Member to receiver Medicaid coverage as early as possible. For this reason, it is critical that providers notify DHP immediately upon learning about a CHIP Member's pregnancy. DHP

will notify HHSC that the CHIP Member is pregnant. Pregnant CHIP Members who are Medicaid eligible will be transferred from CHIP to Medicaid by HHSC.

For CHIP Members who are not Medicaid eligible, DHP will be responsible to cover the costs of the delivery; however, the provider must notify DHP of the delivery by the next Business Day. Newborns of CHIP Members do not automatically become CHIP Members. Upon notification by the provider, DHP will refer the newborn to Medicaid to determine eligibility. Newborns deemed not eligible for Medicaid, will be enrolled in CHIP as determined by HHSC.

For all pregnant CHIP Members, providers should submit to DHP a Pregnancy Notification Form so that the Member may be enrolled in Service Coordination. See **Appendix** for a copy of this form. This includes CHIP Perinate Members.

SECTION B

CHIP Covered Services

Medically Necessary Services

What does medically necessary mean?

Covered services for CHIP Members must meet the CHIP definition of "Medically Necessary." Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the child's/unborn child's physical health and/or the quality of care provided.

CHIP and CHIP Perinate Newborn Covered Services

Driscoll Health Plan provides specific medically necessary services to its CHIP and CHIP Perinate Newborn Members as determined by HHSC. The following table provides an overview of current benefits and limitations under the CHIP program. For the CHIP Perinate (Mother), see the CHIP Section G for a description of the covered services.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the child's physical health and/or the quality of care provided.

Type of Benefit	Description of Benefit	Limitations	Co-Pay
Birthing Care Services	Covers birthing services provided by a licensed birthing center.	• Limited to facility services *(e.g. labor and delivery)*	Co-pays do not apply
Chiropractic Services	Covered services do not require doctor prescription and are limited to spinal subluxation	• Requires authorization for twelve visits per 12-month period limit *(regardless of number of services or modalities offered in one visit)* • Requires authorization for additional visits	Applicable level of co-pay applies to chiropractic office visits
Doctor/Doctor 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)* • Doctor office visits, inpatient and outpatient services	• May require authorization for specialty services	• Applicable level of co-pay applies to office visits • Co-pays do not apply to preventative visits or to prenatal visits after the first visit

Type of Benefit	Description of Benefit	Limitations	Co-Pay

	• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
	• Medications, biologicals and materials administered in doctor's office
	• Allergy testing, serum and injections
	• Professional component (in/outpatient) of surgical services, including:
	  ○ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
	  ○ Administration of anesthesia by doctor (other than surgeon) or CRNA Second surgical opinions
	  ○ Same-day surgery performed in a hospital without an over-night stay
	  ○ Invasive diagnostic procedures such as endoscopic examination
	• Hospital-based doctor services *(including doctor-performed technical and interpretative components)*
	• Doctor and professional services for a mastectomy and breast reconstruction include:
	  ○ all stages of reconstruction on the affected breast;
	  ○ 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 doctor services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
	• Doctor services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation
	• Doctor services associated with
	(a) miscarriage, or
	(b) a non- viable pregnancy *(molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)*		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	• Doctor 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. • 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; ○ 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.		
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Covered services include DME *(equipment that can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home)*, including devices and supplies that are medically necessary and necessary for one or more activities of daily living, and appropriate to help in the treatment of a medical condition, including, but not limited to: • Orthotic braces and Orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs • braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under	• Requires prior authorization and doctor prescription • $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap)	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements		
Emergency Services, including Emergency Hospitals, Doctors, and Ambulance Services	Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and doctor services 24 hours a day, seven days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air or water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	May require authorization for post-stabilization services	Applicable co-pays apply to non-emergency room visits.
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	• Requires prior authorization and doctor prescription • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		• Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
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, are unaffected by electing hospice care services.	• Requires authorization and doctor prescription • Services apply to the hospice diagnosis • Up to a maximum of 120 days with a six (6)-month life expectancy • Patients electing hospice services may cancel this election at anytime	Co-pays do not apply
Inpatient and General Acute and Inpatient Rehabilitation Hospital Services	Services include: • Hospital-given doctor and provider services • Semi-private room and board *(or private if medically necessary as certified by attending)* • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • 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 not given free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests *(facility technical component)* • Laboratory and pathology services *(facility technical component)* • Machine diagnostic tests *(EEGs, EKGs, etc.)*	Requires prior authorization for non-emergency care and following stabilization for an emergency condition Requires authorization for in-network or out-of-network facility and doctor's services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.	Applicable level of inpatient co-pay applies

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	• *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 caesarian section • Hospital, doctor 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 • 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. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for mastectomy and breast reconstruction include: ○ all stages of reconstruction on the affected breast;		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	○ 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		
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	• Requires prior authorization for non-emergency services • Does not require Primary Care Provider referral. • When inpatient psychiatric services, are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Applicable level of inpatient co-pay applies
Inpatient Substance Abuse Treatment Services	Inpatient substance abuse treatment services include, but are not limited to: • inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs	• Requires prior authorization for non-emergency services • Does not require Primary Care Provider referral	Applicable level of inpatient co-pay applies

Type of Benefit	Description of Benefit	Limitations	Co-Pay
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory Services • Radiation and chemotherapy • Blood or blood products not offered free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when offered in a licensed ambulatory surgical facility • Outpatient services associated with (a) miscarriage, or (b) a non- viable pregnancy *(molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)* • Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ○ dilation and curettage (D&C) procedures; ○ appropriate provider administered medications; ○ ultrasounds; and ○ histological examination of tissue samples • 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	May require prior authorization and doctor prescription	• Applicable level of co-pay applies to prescription drug services • Co-pays do not apply to preventative services

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	○ 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 • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ○ all stages of reconstruction on the affected breast; ○ 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		
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)*	• Requires prior authorization. • Does not require Primary Care Provider referral • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or	Applicable level of co-pay applies to office visits

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		termination of services must be presented to the court with jurisdiction over the matter for determination • A Qualified Mental Health Professional – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Applicable level of co- pay applies to office visits. Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or doctor and provides services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in- home services), patient and family	

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		education, and crisis services	
Outpatient Substance Abuse Treatment Services	Outpatient substance abuse treatment services include, but are not limited to: • Prevention and intervention services that are offered by doctor and non-doctor providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four 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.	• Requires prior authorization • Does not require Primary Care Provider referral • Outpatient treatment services up to a maximum of: • Intensive outpatient program *(up to 12 weeks per 12-month period)* • Outpatient services *(up to six-months per 12-month period)*	Applicable level of inpatient co-pay applies
Prescribed Pediatric Extended Care Centers and Private Duty Nursing	A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.	• Requires prior authorization	
Rehabilitation Services	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:	Required prior authorization and doctor prescription	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	• Physical, occupational and speech therapy • Developmental assessment		
Services rendered by a Certified Nurse Midwife or Physician in a licensed birthing center	Covers prenatal, birthing and postpartum services rendered in a licensed birthing center.	Limited to a licensed birthing center	Co-pays do not apply
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and doctor prescription • 60 days per 12-month period limit	Co-pays do not apply
Tobacco Cessation Programs	Covered up to $100 for a 12- month period limit for a plan-approved program	• Requires authorization • Health Plan defines plan-approved program. • May be subject to formulary requirements	Co-pays do not apply
Transplants	Covered services include: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses	Requires authorization	Co-pays do not apply
Vision Benefit	Covered services include: • One examination of the eyes to find the need for and prescription for corrective lenses per 12- month period, without authorization • One pair of non- prosthetic eyewear per 12-month period	• The Health Plan may reasonably limit the cost of the frames/lenses	Applicable level of co-pay applies to office visits billed for refractive exam

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		• Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye	

Current EXCLUSIONS from CHIP Benefits (including CHIP Perinate Newborn)

- Inpatient and outpatient fertility treatment or reproductive services other than prenatal care, labor and deliver, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other article that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Dental devices solely for cosmetic purposes
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Immunotherapy for the treatment of atopic dermatitis
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and doctor services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements offered for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care *(routine foot care does not include treatment injury or complications of diabetes)*
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails *(this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)*
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care *(care that helps a child with the activities of daily living, such as help in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered*

or given by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be given in a public facility or care given while in the custody of legal authorities
- Services or supplies received from a nurse, that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Doctor/ PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

COVERAGE OF DME/SUPPLIES for CHIP and CHIP Perinate Newborn Program
(Does not include CHIP Perinate Member)

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	**Exception**: If given by and billed through the clinic or home care agency it is covered as an incidental supply
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX given at time of dispensing
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings
Arm Sling	X		Dispensed as part of office visit
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply
Batteries – first	X		For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use
Betadine		X	See IV therapy supplies
Books		X	

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Clinitest	X		For monitoring of diabetes
Colostomy Bags			See Ostomy Supplies
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention
Diabetic Supplies	X		Monitor calibrating solution, insulin, syringes, needles, lancets, lancet device, and glucose strips
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan
Diastix	X		For monitoring diabetes
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/ Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when it includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	X		Able to get coverage only if receiving covered home care for wound care
Dressing Supplies/ Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Able to get coverage when used with a covered DME
Enema Supplies		X	Over-the-counter supply

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enteral Nutrition Supplies	X		Necessary supplies *(e.g., bags, tubing, connectors, catheters, etc.)* are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non- function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia
Formula		X	**Exception**: Able to get coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (*expected to last longer than 60 days when prescribed by the doctor and authorized by plan).* Doctor documentation to justify prescription of formula must include: • identification of a metabolic disorder • dysphagia that results in a medical need for a liquid diet • presence of a gastrostomy, or • disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula for Members who could be sustained on an age-appropriate diet. Traditionally used for infant feeding in pudding form *(except for people with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product)* For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	**Exception**: Central line dressings or wound care given by home care agency
Hydrogen Peroxide		X	Over-the-counter supply
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Insulin Pump (External) Supplies	X		Supplies *(e.g., infusion sets, syringe reservoir and dressing, etc.)* are eligible for coverage if the pump is a covered item
Irrigation Sets, Wound Care	X		Able to get coverage when used during covered home care for wound care
Irrigation Sets, Urinary	X		Able to get coverage for person with an indwelling urinary catheter
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes, and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply
Lancet Device	X		Limited to one device only
Lancets	X		Able to get coverage for person with diabetes
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/ IV and Central Line			See IV Therapy and Dressing Supplies/Central Line
Needles and Syringes/Other	X		Able to get coverage if a covered IM or SubQ medication is being administered at home
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		**Items eligible for coverage include**: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant **Items <u>not</u> eligible for coverage include**: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions
Parenteral Nutrition/ Supplies	X		Necessary supplies *(e.g., tubing, filters, connectors, etc.)* are eligible for coverage when the Health Plan has authorized the parenteral nutrition
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			treatments b) as part of covered home care for wound care c) for indwelling urinary catheter irrigation
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes
Tape			See: Dressing Supplies Ostomy Supplies IV Therapy Supplies
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage
Under Pads			See Diapers/Incontinent Briefs/Chux
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit
Urinary, External Catheter & Supplies		X	**Exception**: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan.
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight cauterization
Urine Test Kit	X		When decided to be medically necessary
Urostomy supplies			See Ostomy Supplies

DHP Value Added Services

All Driscoll Health Plan Members may be able to receive the following Extra Benefits (see **Appendix** for Value Added Services).

Non-CHIP Covered Services (Non-Capitated Services)

Non-CHIP Covered Services include the following:

Texas Agency Administered Programs and Service Coordination

Texas Department of Protective and Regulatory Services (TDPRS):

DHP works with TPRS to ensure that the at-risk population, both children in custody and not in custody of TDPRS, receive the services they need. Children who are served by TDPRS may transition into and out of DHP more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area.

During the transition period and beyond, providers must:

- Provide medical records to TDPRS
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by TDPRS
- Participate, when requested by TDPRS, in planning to establish permanent homes for
- Members
- Refer suspected cases of abuse or neglect to TDPRS

For help with Member and TDPRS, providers should call DHP Service Coordination.

Essential Public Health Services

DHP is required through its contractual relationship with HHSC to coordinate with Public Health Entities regarding provision of services for essential public health services. Providers must assist DHP in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by State Law.
- Assisting in notifying or referring to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring to the local Public Health Entity for TB contact investigation and evaluation and preventive treatment of person whom the Member has come into contact
- Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact
- Referring for Women, Infant, and Children (WIC) services and information sharing
- Assisting in the coordination and follow up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment
- Referring lead screening tests to the TDH Laboratory (for levels 5 or higher). To report lead poisoning, the Provider can call **512-458-7269,** or toll free at **1-800-588-1248,** or via fax at **512-458-7699**. The following information must be reported:
  - child's name;
  - address;
  - date of birth;
  - sex;
  - race;
  - ethnicity;
  - blood lead level concentration;
  - test date, name and telephone number of testing laboratory;
  - whether the sample was capillary or venous blood; and
  - The name and city of the attending physician.

Texas Vaccines for Children Program

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled providers for administration to individuals' birth through 18 years of age.

Qualified Medicaid and CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page **http://www.dshs.state.tx.us/immunize/tvfc/default.shtm**.

DHP will pay for TVFC Program provider's private stock of vaccines, but only when the TVFC posts a message on its website that no stock is available. In that case providers should submit claims for vaccines with the "U1" modifier, which indicates private stock. Providers should only submit claims for private stock until the vaccine is available from TVFC again, DHP will no longer reimburse providers for private stock when the TVFC stock is replenished.

Pharmacy Benefit Program

DHP administers the Pharmacy Benefit Program, effective March 1, 2012. DHP subcontracts with a Pharmacy Benefit Manager (PBM) - Navitus, to cover outpatient drugs to pharmacy providers contracted with Navitus, for CHIP Members. The only drugs eligible for reimbursement are those included in the Texas Vendor Program formulary. DHP is however, responsible for assisting its Members with medication management through the PCPs and/or Specialty Care Physicians.

Co-Pay Information for CHIP Members

The following table lists the CHIP co-payment schedule according to family income. No co-payments are paid for preventive care such as well-child or well-baby visits or immunizations.

The DHP CHIP Member ID card lists the co-payments that apply to the Member. The Member must present this ID card when the Member receives services from your office. You are required to collect the co-pay as part of the office visit.

There is no co-pay for:

- Native Americans
- CHIP Perinate Members, or
- CHIP Perinate Newborns.

There is no co-pay for:

- Well-baby checkups
- Well-child checkups
- Preventative checkups, or
- Pregnancy-related services

Federal Poverty Levels	Office Visits	Emergency Room Visits	Inpatient Hospitalizations	Prescription Generic Drugs	Prescription Brand Drugs	Once a Year Reporting Caps
Native Americans	$0	$0	$0	$0	$0	$0
At or Below 100%	$3	$3	$15	$0	$3	5% cap of family yearly income
101%-150%	$5	$5	$35	$0	$5	5% cap of family yearly income
151%-185%	$20	$75	$75	$10	$35	5% cap of family yearly net income
186%-200%	$25	$75	$125	$10	$35	5% cap of family yearly net income

Member's Right to Designate an OB/GYN

DHP allows the Member to pick any OB/GYN but this doctor must be in the same network as the Members Primary Care Provider. Authorization is required for out-of-network 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
- Referral to specialist doctor within the network

SECTION C

Well Child Exams

What is a Well Child Exam?

Well Child Exams are for children's health checkups, and may be referred to as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service. These checkups are important and Members should set up an appointment with their PCP within 45 days of becoming a Driscoll Health Plan Member. Even if a child looks and feels well, he or she may still have a problem.

Well Child Exams can help in many ways. Some of the things done in a medical checkup are:

- Physical exam, measuring height and weight
- Hearing and eye check
- Checking for a good diet
- Immunizations (when needed)
- Blood tests (when needed)
- TB test

Periodicity Schedule and Immunization Requirements

Providers are required to follow the periodicity schedule as defined by the American Academy of Pediatrics (AAP) and/or the Centers for Disease Control and Prevention (**www.cdc.gov**). Providers are required to participate with the Vaccines for Children Program.

Vaccines for Children (VFC) Program

The Texas Vaccines for Children Program provides free vaccines to CHIP children who are younger than 19 years of age that are routinely recommended according to the American Academy of Pediatrics (AAP) immunization schedule. To obtain free vaccine, the provider must enroll in the VFC program through Department of State Health Services (DSHS). There is no reimbursement to providers for vaccines available from VFC. For more information, contact DSHS or Provider Services at the phone number listed at the bottom of this page.

SECTION D

CHIP Appeals, Complaints, Peer-to-Peer Conversations & IRO Processes

Peer-to-Peer Conversations

Peer-to-Peer conversations non-certification decisions are available to Providers, pre and post determination, and are the most timely and direct process to facilitate exchange of information in support of the authorization process.
Peer Clinical Reviewers are available to discuss non-certification decisions with Attending Provider or other Ordering Provider via the Toll Free UM line at 1-877-455-1053 (CHIP/STAR/STAR Kids) during normal business hours Monday - Friday from 8 a.m. to 5 p.m., except for legal holidays.

Peer-to-Peer Availability Prior to Decision
Driscoll Health Plan (DHP) affords the Provider with a reasonable opportunity to discuss the Member's treatment plan and the clinical basis of a non-certification decision with the original Peer Reviewer prior to issuing an adverse determination. The reasonable opportunity timeframe is defined as:

- One (1) Business Day for a routine, prospective review;
- Five (5) Business Days for a retrospective review; and
- Prior to issuing, for a concurrent or post-stabilization review.

If the original Peer Reviewer cannot be available within one (1) Business Day, another Peer Reviewer will be available for the conversation.

Peer-to-Peer Post-Decision
When DHP makes a non-certification decision, and no peer-to-peer conversation has occurred in connection with the case, DHP provides, within one (1) Business Day of a request by the Attending Provider or other Ordering Provider, the opportunity to discuss the non-certification decision:

a) With the Clinical Peer Reviewer making the initial determination; or
b) With a different Clinical Peer, if the original Clinical Peer Reviewer cannot be available within one (1) Business Day.

For CHIP, STAR and STAR Kids non-certification decisions, the *Peer-to-Peer Conversation Availability* form is sent via facsimile and/or the Provider or facility receives notification via phone. Additionally, Peer-to-Peer opportunity offer for non-certification decisions is included in the *Notification of Referral Status* facsimile.

If a peer-to-peer conversation or review of additional information does not result in an authorization (certification), DHP informs the Provider and Member of the right to initiate an appeal and the procedure to do so.

What is an Appeal?

An appeal is a request from the member or provider on behalf of a member to review the determination of a denial, reduction, suspension, or termination of a service. Appeals are processed in separate and distinct departments dependent upon the categorization of the appeal. DHP Member Services are available to assist those members requiring assistance with the filing of a Member Appeal. This section outlines these processes.

Member Appeals
There are four (4) types of member appeals. They are:

1) *Member Adverse Medical Determination Appeal* - an appeal that occurs when there has been a denial of benefit due to lack of medical necessity.

2) *Expedited Appeal* - an appeal at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the Member's health.
3) *Administrative Denial Appeal*- a request for a review of an Administrative Denial, which has been denied for technical or non-medical reasons.
4) *Pharmacy Appeal*- an appeal that occurs when there has been a denial of pharmaceutical benefits from the preferred third-party vendor from DHP.

Filing a Member Appeal
A Member or Member's Legally Authorized Representative (LAR) may request an appeal with the Member's written consent. You may request an appeal by phone or in writing. Oral request must be submitted in writing and signed by Member or LAR. A Member Advocate is available to assist with the filing of an appeal. This includes help with filing an Expedited Appeal.

Submit Member Appeals as follows:

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2186 **Email:** DHP___QM___Appeals@dchstx.org
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Member Appeals Department 4525 Ayers St. Corpus Christi, Texas 78415	

How will I be notified if services are denied?
The Member/Provider is notified in writing of the denial of services within three (3) Business Days of the decision.

Member Adverse Medical Determination Appeal Process
If the DHP Medical Director determines that requested services do not meet medical necessity criteria or if the request for services is not covered or limited, then services may be denied. In such case, a denial letter is sent to the Provider and Member setting forth the basis for the denial, along with the process to initiate an appeal.

A Member/Provider may submit an appeal orally or in writing 60 days from the date of the Denial of Action letter. An acknowledgement letter will be sent to the Member/Provider within five (5) Business Days of receipt of the appeal and a Peer-to-Peer Conversation Availability Notification will be sent to the provider of service. If the appeal is submitted orally, an appeal form will be sent to the Member/Provider with the acknowledgement letter. The form must be completed, signed, and returned to DHP.

In order to ensure that there is continuity of current authorized services, the Member, Provider, or someone acting on behalf of the Member, should file the appeal on or before the later of:
(a) 10 days following the mailing of the notice of action, or
(b) the intended effective date of the proposed action.

A Medical Appeal Reviewer of like specialty who did not participate in the original denial will review the appeal request. The entire process from receipt of the oral or written appeal to resolution will be completed within 30 calendar days of receipt of the appeal request.

Written notice will include the process to file a complaint if the member does not agree with the decision to delay. The Provider/Member will be sent a decision letter summarizing the rationale for the decision, the name of any physician(s) or health care provider(s) and information regarding a second level specialty review appeal.

A second level specialty review appeal must be received within 10 Business Days from the date of the denial of the appeal, and the provider must set forth in writing to DHP, good causes for having a particular type of a specialty provider review the case. DHP will acknowledge the letter within five (5) Business Days of the request for a specialty review, have the denial reviewed by a health care provider in the same or similar specialty as typically manages the condition or treatment, and complete the specialty review within 15 Business Days of receipt of the request. The decision letter for this specialty review will include information on the Independent Review Organization (IRO) appeal process through the Texas Department of Insurance.

Appeals for denials of service for non-covered benefits are considered complaints, and they are not eligible for appeal. Members also have a right to request an appeal for denial of payment for services in whole or in part and should be submitted. Members may be required to pay the cost of services furnished while the appeal is pending, if services were delivered before approval was given.

Expedited Appeal for CHIP Member
A Member/Provider may request an Expedited Appeal if he/she believes a Member's life or health could be jeopardized by the time frames involved in the normal appeal process. Members/Providers may file the request in writing. During and expedited appeal, the DHP Chief Medical Officer health care provider who has not previously reviewed the case will review the appeal. DHP will make a determination to proceed as an Expedited Appeal, or process as a Standard Appeal Verbal notification of this decision will be provided within 24 hours or the next business day, whichever one is sooner. The expedited appeal will be completed no later than one (1) Business Day following the day on which the appeal, including all information necessary to complete the appeal, is made to DHP.

If the appeal involves a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment of the disease or condition is interrupted, the Member/Provider may request the case be directly forwarded to an IRO. This process must be initiated by DHP, so it is imperative that the Member/Provider complete and submit the proper forms to DHP as soon as possible. See below for more information on the IRO process.

DHP will make every effort to honor the Members/Providers request for an expedited appeal. If the rationale for the request does not meet the definition of an expedited appeal, DHP may deny the request for an expedited appeal. If this happens, the provider may discuss the situation directly with the Chief Medical Officer by calling the Provider Services at the number listed at the number listed at the bottom of this page.

If the Member, or someone acting on their behalf, needs help with filing an Expedited Appeal, you may call the DHP Provider Services phone number at the bottom of this page, or 1-877-451-5598 and a Customer Service Representative will help.

Independent Review Organization Appeal through TDI for CHIP Members

CHIP Members may request an appeal to an Independent Review Organization (IRO) through the Texas Department of Insurance (TDI). An IRO is an outside organization assigned by TDI to review the health plan's denial of services. Direct appeals to the IRO are available for those cases that involve a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment for the disease or condition is interrupted. In addition, CHIP Members have the right to request an IRO for non-life-threatening disease or conditions after exhausting the DHP internal appeal process.

DHP must initiate this IRO process. To request an IRO, the Member/Provider should contact Provider Services at the phone number listed at the bottom of the page. If the Member is requesting an IRO review, the Member should contact Customer Service at 1-877-451-5598. DHP will provide the Member/Provider with the necessary forms that must be completed and returned to DHP. Member advocates are available to assist Members with this process.
Upon receipt of all required forms, DHP will send the request to TDI, who will appoint the IRO to review the case within one (1) Business Day of receipt of the request. TDI will notify the Member/Provider and DHP who was appointed as the IRO. DHP will then submit any additional required documentation to the IRO within three (3) Business Days of the appointment of the IRO.

For a life-threatening condition, the IRO will make a decision no later than the fifth (5th) day after the date they receive the information necessary to make the determination from DHP, or the eighth (8th) day after the they receive the request that the determination be made.

For other than life-threatening conditions, the IRO will make a decision no later than the fifteenth (15th) day after the date they received the information necessary to make the determination from DHP, or the twentieth (20th) day after they receive the request that the determination be made.

Decisions of the IRO are final and binding. DHP will abide by the decision of the IRO and will be responsible for paying fees to the IRO for their review, as required by the Texas Department of Insurance Commissioner.

Administrative Denial Appeal Process
Contractual Denials are denials based upon a Provider's failure to follow the terms and conditions of the Provider's contract with DHP and applicable policies and procedures include, but are not limited to:

- Failure to obtain prior authorization.
- Failure to notify DHP prior to transfer.
- Failure to notify DHP of a hospital admission within stated timeframes.

A Provider/Member may submit an appeal orally or in writing 60 days from the date of the Administrative Denial letter for technical and non-medical reasons. An acknowledgement letter will be sent to the Provider/Member within five (5) Business Days of receipt of the appeal. If the appeal is submitted orally, an appeal form will be sent to the Provider/Member with the acknowledgement letter. The appeal form must be completed, signed, and returned to DHP as required by Texas Insurance Code. DHP will review the request for Administrative Denial Appeal and issue a response letter to the Provider, Member or Members representative with an explanation of the decision within thirty (30) calendar days.

Pharmacy Appeal Process
If the DHP preferred third party vendor pharmacy benefit managers (PBM) determines that requested services do not meet criteria or if the request for services is not covered or limited, then services may be denied. In such case, a denial letter is sent to the Provider and Member setting forth the basis for the denial, along with the process to initiate an appeal. Providers/Members may submit an appeal orally or in writing 60 days from the date of the Denial of Action letter. An acknowledgement letter will be sent to the Provider/Member within five (5) Business Days of receipt of the appeal. If the appeal is submitted orally, an appeal form will be sent to the Provider/Member with the acknowledgement letter. The form must be completed, signed, and returned to DHP.

The appeal request will be reviewed by a Medical Appeal Reviewer of like specialty who did not participate in the original denial. The entire process from receipt of the oral or written appeal to resolution will be completed within 30 calendar days of receipt of the appeal request. The timeframe may be extended up to 14 calendar days if the Member requests an extension, or if DHP shows that there is a need for additional information and how the delay is in the Member's interest. Within 2 calendar days from the decision to delay, DHP will give the Member written notice of the reason for delay if the Member has not requested the delay. Written notice will include the process to file a complaint if the member does not agree with the decision to delay Appeal for denials of service for not being a covered benefit is a complaint, not an appeal for adverse determination.

Provider or Member may request an IRO after exhausting the DHP internal appeal process.

Members also have a right to request an appeal for denial of payment for services in whole or in part. Members may be required to pay the cost of Pharmacy/Medication furnished while the appeal is pending, if Pharmacy/Medication were delivered before approval was given.

What is a Complaint?

Complaints Introduction

DHP has established procedures for the handling and resolution of complaints and appeals. DHP Member Services are available to assist those members requiring assistance with the filing of a complaint or appeal. This section outlines these processes

Complaint: Any dissatisfaction expressed orally or in writing by a complainant to DHP regarding any aspect of DHP operations including but not limited to: dissatisfaction with plan administration, procedures related to review or appeal of an adverse determination under the Texas Insurance Code (TIC) § 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include:

- a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the member; or
- a provider's or member's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Member Representative: An "authorized representative" is a person or entity that assists with a complaint on the member's behalf, including but not limited to, a family member, friend, guardian, legally authorized representative (LAR), provider, an attorney or provider of record. The member must designate a representative in writing.

Filing a Complaint

A Member, Provider or someone acting on behalf of a Member or Provider ("Complainant"), may file a complaint orally or in writing. A Member advocate is available to assist members with the filing process of a complaint.
Submit Complaints as follows:

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2186
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Member Appeals Department 4525 Ayers St. Corpus Christi, Texas 78415	
Email: DHP_QM_Complaints@dchstx.org	**Provider Portal:** ***(Providers Only)*** www.driscollhealthplan.com

Complaint Process and Resolution

DHP Performance Excellence Team handles all member and provider complaints. The processing of a complaint is described as follows:

Initial Complaint Process- a complaint resolved within one (1) Business Day.
Formal Complaint Process- a complaint resolved within 30 Business Days in which:

- Members and Providers may submit their complaint verbally or in writing.
- **CHIP Only (TDI requires)**: For verbal complaints, a one-page complaint form, with instructions and a stamped, self-addressed envelope are provided by DHP. The form must be returned to DHP for prompt resolution of the complaint.
- Acknowledgement: Within five (5) Business Days of receipt of the complaint, an acknowledgement letter is sent to the Member or Provider.
- Investigation: Referrals to other departments are made as appropriate including the review and consideration of all documents submitted by the member or provider.
- Resolution: Written resolution is sent to the member or provider within thirty (30) days.

The resolution letter will contain a complete description of the process for filing a complaint appeal, including the deadlines for the complaint appeal process and for a final appeal decision as well as contact information for TDI if complainants are not satisfied with the resolution.

CHIP Complaint Appeal Process:
If a complainant is not satisfied with the resolution of a complaint, DHP provides a complaint appeal process.

a. Upon receipt of the written complaint appeal request, an acknowledgement letter is sent within five (5) Business Days. The complainant is required to submit the complaint appeal in writing. A one-page complaint appeal form with instructions is sent to the complainant.
b. The acknowledgment letter will include the DHP complaint appeal process, the timeframe, and the complainant's right to appear before the Complaint Appeal Panel.
c. The complaint appeal process must be completed within ~~thirty (~~30~~)~~ calendar days from the date the written request for an appeal is received.
d. Written notification of the final complaint appeal panel decision includes a statement of the specific medical determination, clinical basis, and contractual criteria used to make the decision, and contact information for TDI.

A complaint appeal involving ongoing emergency or continued hospitalization shall be investigated and resolved in accord with:

a. the medical immediacy of the case; and
b. not later than 1 Business Day after the complainant's request is received

DHP shall provide instead of a complaint appeal panel a review by a physician or provider who:

a. has not previously reviewed the case; and
b. is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

If I am not satisfied with the outcome of Complaint Appeal Process who else can I call?
If the Complainant is not satisfied with the complaint resolution, the Complainant has the right to contact the Texas Department of Insurance at the address/phone number below.

Toll Free Customer Service: 1-800-252-3439

Complaints in writing may be forwarded as follows:

Texas Department of Insurance
Consumer Protection, MC: CO-OP
P.O. Box 12030
Austin, Texas 78711-2030
Email: ConsumerProtection@tdi.texas.gov
Online: https://www.tdi.texas.gov/hprovider/index.html

Provider Dispute Resolution for Administrative Issues

If a provider is not satisfied with the resolution response made through the Complaint Process, the provider may request provider dispute resolution with DHP. The dispute resolution process is for administrative issues only and may not be used for disputes related to credentialing or disciplinary action. The provider may also escalate the dispute to HHSC or TDI if preferred. If the issue claims and/or payment related, the provider must complete DHP's internal appeal process prior to escalation to a provider dispute resolution.

- Providers must submit a request for dispute resolution in writing via email, fax or mail no later than 30 calendar days from the resolution letter.
- Acknowledgement: Within five (5) Business Days of receipt of the request for dispute resolution, an acknowledgement letter is sent to the provider.
- Investigation: Review and consideration of all documents submitted in the complaint process will be forwarded to Executive Leadership for final determination as appropriate. Additional information may not be submitted for review in the dispute resolution process.
- Resolution: Written dispute resolution is sent to the provider within thirty (30) days.

DRISCOLL HEALTH PLAN	
Toll Free Customer Service: 1-877-220-6376 (Nueces) 1-855-425-3247 (Hidalgo)	**Fax:** 361-808-2725 **Email**: DHP_QM_Complaints@dchstx.org
Mail: DRISCOLL HEALTH PLAN Quality Management Department ATTN: Performance Excellence Team 4525 Ayers Street Corpus Christi, Texas 78415	

Provider Disputes Concerning Professional Competence or Conducts

Dispute Resolution

All professional review actions based on reasons related to professional competence or professional conduct that affects or could affect adversely the health or welfare of a patient or patients and that adversely affect a Provider's privileges for a period of longer than 30 days must be reported in accordance with Public Law 99-6660 and the Healthcare Quality Improvement Act of 1986. See, 45 CFR 60.9. The process described herein applies to all contracted Providers, delegated and non-delegated.

In compliance with state and federal regulations, URAC standards, and Driscoll Health Plan (DHP) internal standards, Driscoll Health Plan must report to appropriate monitoring agencies, e.g., the Texas Board of Medical Examiners, Health Integrity Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider's privileges of participation, or denial of acceptance to DHP. In the event that DHP takes an action to terminate, suspend or limit a Provider's participation status with DHP, Driscoll Health Plan will provide a dispute resolution process as delineated:

Case Identification and Initial Review

A case concerning professional competence or conduct may be identified by any DHP department and a referral for Initial Review initiated by any Director of Driscoll Health Plan, the Quality Management Department, the Chief Medical Officer

(CMO), the Medical Director or Credentialing and Peer Review Committee (CPRC), or the Executive Quality Committee (EQC). The initial review will be conducted by, or under the direction of the CMO. The initial review process is not an appeal hearing. An initial review may involve consultation with the Provider, the individual or group making the request or other individuals who may have knowledge of the events, the Special Investigative Unit (SIU)or other Providers as deemed appropriate by the CMO. The initial Review may result in no action or may result grading of the issue from Level 1 – Level 4. In severity. For recommendations of a Level 3 or higher severity, The CMO refers the case to the Credentialing and Peer Review Committee (CPRC) for formal review.

In the case of a serious offense or an imminent risk to member health and safety, an expedited investigation is performed by the CMO, CPRC and ELC with appropriate interventions implemented up to and including immediate suspension and/or termination.

Formal Review
The CPRC convenes in accord with peer review statutes and reviews all available information form the Provider and other sources prior to making a decision. Upon a comprehensive review, the CPRC makes a formal recommendation up to and including suspension or termination. The recommendation is reviewed in conjunction with the Executive Quality Committee (EQC)/Executive Leadership Committee (ELC) for final disposition which may result in a reduction in severity grading of the issues or in actions up to suspension or termination of participation in the Driscoll Health Plan. The provider receives written notice of the adverse action to include the reason for the action, description of desktop review process or. details of the in-person hearing, reference to the evidence/documentation for the action, right to an in person hearing and to have legal counsel. In response to such adverse action, the Provider will be given 30 days to request initiation of an appeal hearing. If the Provider fails to submit a request for an appeal hearing, the adverse action is considered final.

Appeal Hearing (Appeals)
Level 1: The first-level appeal panel consists of at least three contracted Providers who are not otherwise involved in the day-to- day operations of DHP, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier action. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report for the CMO and EQC/ELC for implementation of their recommendation. If the appeal panel's findings result in upholding the limitation, suspension or termination, the Provider will be notified of the appeal panel's findings and given 10 business days to request a second appeal hearing for reconsideration of the action.

Level 2: The second-level appeal panel will consist of at least three contracted Providers who are not otherwise involved in the day-to-day operations of DHP, at least one of which must be of same or similar specialty to the Provider filing the dispute, and who were not previously involved in the earlier actions. The appeal panel will convene within 60 days of the notice of adverse action. At the appeal hearing, the requesting Provider may appear in person, submit supporting documentation, and be accompanied by a representative. Upon conclusion of the appeal hearing, the appeal panel will prepare a report for the CMO and EQC/ELC for implementation of their recommendation. The Provider will be notified of the second appeal panel's findings, which are considered final.

Reapplication Subsequent to Adverse Action
A Provider who has had an adverse action taken against him/her may not reapply for network participation for a period of two year (24 months) unless specified otherwise in the terms of the adverse action.

SECTION E

CHIP Member Rights and Responsibilities

Member Rights

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

2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider 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 are 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 decides those things.

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

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

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

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

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

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

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

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

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

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

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

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

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

19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them.

8. You must report misuse of CHIP services by health care providers, other Members, or health plans.

9. Talk to your child's provider about all of your child's medications.

SECTION F

CHIP Perinate Covered Benefits

Covered services for CHIP Perinate Members must meet the CHIP Perinate Program definition of "Medically Necessary."

What are Medically Necessary Services?

Medically Necessary Services are health services that are:

Physical:

- reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of an unborn child, or endanger life of the unborn child;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of an unborn child's medical conditions;
- consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- consistent with diagnoses of the conditions; and
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not experimental or investigative; and
- are not primary for the convenience of the mother of the unborn child or health care provider.

Behavioral:

- reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improved, maintain, or prevent deterioration of function resulting from the disorder;
- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not experimental or investigative; and
- are not primary for the convenience of the mother of the unborn child or health care provider

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the unborn child's physical health and/or the quality of care provided.

For the CHIP Perinate (Mother), the Covered Benefits are limited.

CHIP PERINATE MEMBER PROGRAM EXCLUSIONS FROM COVERED SERVICES (MOTHER)

- For CHIP Perinate in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.

- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post-partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
  Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care *(routine foot care does not include treatment of injury or complications of diabetes).*
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails *(this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).*
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes
- Custodial care *(care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)*
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that does not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursements for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.

- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?

Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. An "Emergency Medical Condition" is a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the unborn child's health in serious jeopardy;
- serious impairment to bodily functions as related to the unborn child;
- serious dysfunction of any bodily organ or part that would affect the unborn child;
- serious disfigurement to the unborn child; or
- In the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

"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 average knowledge of medicine and health:

- requires immediate intervention and/or medical attention without which the mother of the unborn child would present an immediate danger to the unborn child or others; or
- that renders the mother of the unborn child incapable of controlling, knowing or understanding the consequences of her actions.

What are Emergency Services and/or Emergency Care?

"Emergency Services" and/or "Emergency Care" are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition, including post-stabilization care services related to labor and delivery of the unborn child.

Member's Right to Designate an OB/GYN

DHP <u>DOES NOT LIMIT</u> TO NETWORK
DHP allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's primary Care Provider or not. Authorization is required for out-of-network 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
- Referral to specialist doctor within the network

SECTION G

CHIP Perinate Member Rights and Responsibilities

Member Rights

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

2. You have a right to know how the perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others are 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 and/or medically necessary. You have the right to know about the people in the health plan who decides those things.

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

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

6. You have a right to emergency perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.

7. You have the right and responsibility to take part in all the choices about your unborn child's health care.

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

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

10. You have the right to talk to your perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.

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

12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities

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

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the 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 Perinate Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinate Program 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 (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr**.

SECTION H

Billing for CHIP Perinate Services

Claims for Professional Services

Claims for professional services that are covered by the CHIP Perinate Program can be billed to DHP. Please refer to the *"Section VIII – Claims"* for detailed billing information.

Claims for Delivery and Postpartum Services

DHP covers prenatal care, labor with delivery, and two postpartum visits between 7 and 60 days after delivery or end of pregnancy. Obstetrical delivery may be billed to DHP with one of the following CPT codes:

CPT	DESCRIPTION
59410	Vaginal delivery only; including postpartum care
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery; including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Delivery only and postpartum only care services may be billed to DHP with the following CPT codes:

CPT	DELIVERY DESCRIPTION
59409	Vaginal delivery only
59514	Cesarean delivery only
59612	Vaginal delivery only, after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

CPT	POSPARTUM VISIT DESCRIPTION
59430	Postpartum care only (separate procedure)

Important Information about Hospital Claims

Labor with delivery facility claims for Perinate Mothers will be paid by two sources:

- Claims for mothers at 185% FPL and under will be submitted to the Texas Emergency Medicaid Program. Claims sent to DHP for these services will be denied as not a covered benefit.
- Claims for Perinate Mothers between 186-200% FPL will be submitted to DHP for payment.

Claims for facility charges for Perinate Mothers 185% FPL and under can be sent to:

Texas Medicaid and Health Care Partnership Claims
P.O. Box 200555
Austin, Texas 78720-0555

Please check the Member's ID card for billing information to avoid delays in claim payments.

SECTION I

Provider Responsibilities for CHIP Perinate

Expectant Mother Enrolled in CHIP Perinate

Expectant mothers enrolled in CHIP Perinate will not have an assigned PCP on their ID card. Since benefits are limited to prenatal care only, there will be a pregnancy care provider listed which may be a Family Practice Physician, OB/GYN Physician, Internal Medicine Physician, Advanced Nurse Practitioner, Certified Nurse Midwife, or Clinic.

CHIP Perinate Newborns

Once the CHIP Perinate mother delivers, DHP will work with the mom to select a PCP for her newborn. The provider can assist the mother with this process by calling the Provider Services numbers listed below.

HHSC encourages Providers participating in the CHIP Perinate program to practice the “medical home concept” for members with CHIP Perinate benefits. To realize the maximum benefit of health care, each family and individual needs to be a participating Member of a readily identifiable, community-based medical home. The medical home provides primary medical care, preventive health services and is the individual’s, and family’s initial contact point when accessing health care. It is a partnership among the individual and family, health care providers within the medical home and network of consultative and specialty Providers with whom the medical home has an ongoing and collaborative relationship. The Providers in the medical home are knowledgeable about the individual’s and family’s specialty care and health related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, specialty/hospital services and health-related services, the medical home maintains the primary relationship with the individual and family keeps abreast of the current status of the individual and family through a planned feedback mechanism and accepts them back into the medical home for continuing primary medical care and preventive health services.

Referrals to Specialists and Health-Related Services

All referrals to Specialists for a CHIP Perinate Mother must be related to the Pregnancy care only and subject to the covered services and benefit limitations.

Appendix