Parkland
Community Health Plan

Medicaid and CHIP Provider Manual
April 2021

1341 West Mockingbird Lane, Suite 400E, Dallas, Texas 75247

Parklandhealthplan.com

To learn more, please call **1-888-672-2277 HEALTH*first*** or **1-888-814-2352 KIDS*first***

Dallas Service Area - Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall

TXP-15-09-01 (Rev 4/21)

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SECTION I
Quick Reference Phone List

Parkland Community Health Plan Phone List

Resource	Contact Information
TTY (STAR)	1-800-735-2989
TTY (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-800-735-2989
24-Hour Behavioral Health Hotline (STAR)	1-800-945-4644
24-Hour Behavioral Health Hotline (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-800-945-4644
CHIP/STAR Case & Disease Management	1-888-413-0967
Parkland 24hr Nurse Line (STAR)	1-888-667-7890/ 214-266-8773
Parkland 24hr Nurse Line (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-800-357-3162/ 214-266-8766
PCHP Waste Abuse Fraud Hotline	1-800-351-0093
Member Services (STAR)	1-888-672-2277 (Option 3)
Member Services (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-888-814-2352
Provider Services (STAR)	1-888-672-2277 (Option 2) 1-800-240-1131 (Fax)
Provider Services (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-888-814-2352 (Option 2)
Claims Administration (STAR)	1-888-672-2277 (Option 4)
Claims Administration (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-888-814-2352 (Option 4)
Case Management (STAR)	Secure Web Portal link on the website **www.parklandhealthplan.com** 1-888-672-2277 (Option 3) 1-214-266-2097 (Local Fax) 1-844-306-2430 (Toll-Free Fax)
Case Management (CHIP, CHIP Perinate, CHIP Perinate Newborn)	Secure Web Portal link on the website **www.parklandhealthplan.com** 1-888-814-2352 (Option 3) 1-214-266-2097 (Local Fax) 1-844-306-2430 (Toll-Free Fax)
Covered Person Eligibility	Secure Web Portal link on the website **www.parklandhealthplan.com**
Claims Status	Secure Web Portal link on the website **www.parklandhealthplan.com**

Prior Authorizations	Secure Web Portal link on the website **www.parklandhealthplan.com** 1-1-214-266-2085 (Local Fax) 1-844-303-1382 (Toll-Free Fax)
Concurrent Review	Secure Web Portal link on the website **www.parklandhealthplan.com** 1-214-266-2084 (Local Fax) 1-844-303-2807 (Toll-Free Fax)

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	1-512-458-7151
CHIP application and enrollment assistance	1-800-647-6558
Comprehensive Care Program/TMHP	1-800-925-9126
Dental Contractors (STAR)	DentaQuest -1-800-685-9971 MCNA Dental -1-800-494-6262
Dental Contractors (CHIP, CHIP Perinate, CHIP Perinate Newborn)	DentaQuest -1-800-516-0165 MCNA Dental -1-800-494-6262
Vision Member Services (STAR)	1-800-879-6901
Vision Member Services (CHIP, CHIP Perinate, CHIP Perinate Newborn)	1-800-879-6901
Early Childhood Intervention (ECI) Care Line	1-800-628-5115
Eligibility Line (STAR) - Automated Inquiry System (AIS)	1-800-925-9126
Texas Medicaid Managed Care Helpline	1-800-964-2777
Medical Transportation Services (STAR)	1-855-687-3255
Pharmacy Provider Help Desk (Navitus)	1-877-908-6023
Pharmacy (Vendor Drug Program) Questions	1-800-435-4165
Texas Health Steps – Dallas	1-877-847-8377
Texas Vaccines for Children Program	1-800-252-9152
TMHP (To enroll as a Texas Health Steps Provider)	1-800-925-9126 (Option 2)
Women, Infant, Children (WIC)	1-800-942-3678

Parkland
Community Health Plan

Section II
Introduction

Parkland Community Health Plan's Background

Welcome to Parkland Community Health Plan (PCHP). PCHP is pleased you have decided to participate with the Parkland HEALTH*first* STAR (Medicaid), KIDS*first*, the Children's Health Insurance Program (CHIP)/CHIP Perinate Newborn and/or the CHIP Perinate (future reference is CHIP) or other programs sponsored by PCHP.

The PCHP programs are dedicated to delivering quality health care to the community we serve and the impact that these programs have on our Covered Persons' ability to function and live productive lives. PCHP actively seeks to understand and then focus on barriers to care created by social needs. PCHP currently offers Medicaid and CHIP benefits to eligible recipients who live in the Dallas Service Area, which includes Dallas, Collin, Rockwall, Kaufman, Navarro, Hunt and Ellis counties.

This Manual contains information to assist you in doing business with PCHP and the State Programs and allows you more time to focus on what's important to you – the health and wellbeing of your patients.

PCHP Mission Statement

- Our Purpose
    - Parkland Community Health Plan exists to provide access to high quality healthcare services, in partnership with our providers and stakeholders in the communities we serve. We want to change the way communities think about healthcare by connecting people to meaningful health and wellness experiences.

Name Recognition

Parkland Community Health Plan (PCHP) was started in 1999 by Parkland Health & Hospital System. For more than a century, Parkland is the name that families in North Texas recognize and trust when it comes to all aspects of medical care. We offer STAR and CHIP services for children, teens, pregnant women and adults. We are proud to be locally owned and locally operated.

These health insurance programs cover doctor visits, regular checkups, immunizations, lab and x-rays tests, hearing and vision tests, hospitalization, surgery, emergency services, urgent care services, home health care, DME/medical equipment, and more.

We have more than 6,000 doctors and specialists and more than 40 hospitals and urgent care centers in our network to give you health care if you qualify for Medicaid or CHIP. The hospitals in our network include Parkland and Children's Medical Center, and many others. The doctors include pediatricians, specialists, and main doctors who can provide routine checkups and immunizations.

Products

PCHP functions as an administrator for:

- CHIP
- STAR

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

Children's Health Insurance Program (CHIP)

PCHP has been a CHIP contractor since 2000. The program is designed for families who earn too much money to qualify to Medicaid yet cannot afford to buy private insurance for their children. CHIP provides eligible children (up to age 19) with treatment for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, x-rays, hospital services (inpatient, outpatient and emergency room), and more.

STAR/Medicaid Managed Care

PCHP has been a STAR contractor since 1999. The STAR program provides a full range of Medicaid health services to newborn, pregnant women, children, and adults.

PCHP Philosophy of Business

PCHP has established a cohesive collaboration with its physician network; one that strives to be inclusive and educative rather than punitive. This approach has gained PCHP 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 North Texas area. These strong and mutually beneficial relationships have come together to ensure excellence in the delivery of health care services to PCHP Members, PCHP and community physicians have collaborated on programs that benefit not only the enrolled Members of the health plan, but the entire community.

PCHP Program Objectives

We have identified specific objectives to effectively manage and provide quality health care for the Parkland Community Health Plan Medicaid and CHIP Members. The objectives are:

- To ensure network adequacy and timely access to care
- To provide timely claim payment
- To provide comprehensive behavioral health care
- To incorporate a cultural competency program to address the diverse cultural needs of our members and provide disease management programs appropriate for the populations we serve.

PCHP & Contracted Providers Discrimination Policy

Non-Discrimination

PCHP shall comply with Title VI of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Federal Rehabilitation Act of 1973, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide in part that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in or denied any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds. PCHP agrees to comply with the Texas Health and Safety Code, as amended, relating to workplace and confidentiality guidelines regarding AIDS and HIV, currently cited in Section 85.113. PCHP agrees that it shall not discriminate against any individual based on that individual's pre-existing medical condition or disability.

All PCHP contracted providers must comply with: All State and Federal Anti-discrimination laws to include but not limited to:

a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000D et seq) and applicable 45 CFR Part 80 or 7 CFR Part 15
b. Section 504 of the Rehabilitation Act of 1973 (29 USC 794) and Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq)
c. Age Discrimination Act of 1975 (42 U.S.C. 6101-6107)
d. Title IX of the Education Amendments of 1972(20 U.S.C. 1681-1688)
e. Food Stamp Act of 1977 (7 U.S.C. 200 et seq)
f. Executive Order 13279, and it's implementing regulations at 45 CFR Part 87 or & CFR Part 16
g. The HHS agency's administrative rules as set forth in the Texas Administrative Code, to the extent of this agreement

Definitions

Capitalized words in this Manual are defined terms; the definitions are below.

Admission. An Admission occurs when a Covered Person is admitted to an acute care Facility for at least 24 hours.

Ancillary Services Provider. Ancillary Services Providers include chiropractors; home health services providers; DME suppliers; mental health, behavioral health and chemical dependency service providers; emergency ambulance and related services; pharmacies; optometrists; labs; diagnostic imaging facilities; registered dieticians; audiologists; physical, occupational, speech and related therapists; and other providers which may provide Covered Services, all of which must be licensed by the State of Texas and credentialed by PCHP.

Appeal. If PCHP terminates a Participating Provider's contract, or denies a Provider credentials, the Provider may appeal the Initial Decision under the process described by state law, PCHP's Quality of Care Policy and its Credentialing Plan available at www.parklandhealthplan.com.

Appeals/Peer Review Sub-committee. is a committee composed of Participating Providers that will be constituted according to state law and NCQA standards to review any Participating Provider Appeal of an Initial Decision and recommend to PCHP whether the Initial Decision should be upheld or reversed. If necessary, to comply with State Law or NCQA requirements, PCHP may request a non-contracted provider not in direct competition with the Participating Provider who has filed an Appeal to serve on the Appeals/Peer Review Committee. This sub-committee may also be asked to oversee other peer review activities.

Associated Health Professional. Nurse practitioner; clinical nurse specialist; certified registered nurse anesthetist; midwife; or physician's assistant who is employed by or is an independent contractor to the Provider, provided that the Provider bills directly for the Covered Services provided by the Associated Health Professional, using CPT Codes and modifiers as needed to reflect the use of an Associated Health Professional.

Authorized Representative. An Authorized Representative of a Covered Person is legally authorized to act on behalf of the Covered Person with respect to health care and related decisions. Authorized Representatives may be parents or foster parents of a minor, a legal guardian or a person authorized in writing to act on behalf of the Covered Person.

Checkup. Checkup is a Texas Health Step Checkup upon enrollment, for preventative visits, and for pregnant teens.

CHIP Perinatal. CHIP Perinatal describes when HHSC contracts with PCHP to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Covered Persons.

CHIP Perinate. CHIP Perinate means a pregnant female Covered Person who is enrolled to receive Covered Services from PCHP.

CHIP Perinate Newborn. CHIP Perinate Newborn means a CHIP Perinate Covered Person.

Clean Claim. The content of a Clean Claim is set forth in Appendix U to this Provider Manual.

Complaint. A Complaint is any dissatisfaction, expressed by a complainant orally or in writing to PCHP, with any aspect of PCHP's operations, including, but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of claim denials or pre-authorization/referral requests; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. A Complaint is not related to misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the PCHP provider.

Corrective Action Plan ("CAP"). A Corrective Action Plan may be offered to a Participating Provider who PCHP has reason to believe may not be complying with his/her/its contract with PCHP and/or is engaging in practices which raise a Quality of Care Issue or a Quality of Care Concern or a Service Issue for Covered Persons and/or PCHP.

Covered Person/Member. A Covered Person (or a "Member") is eligible for participation in a State Program and is either assigned to PCHP by the State Agency supervising the specific State Program or chooses PCHP and is properly enrolled in one of PCHP's health plans.

Covered Services. Covered Services are health care services/supplies/items which a Covered Person is entitled to receive under the State Programs and the Parties' agreement.

Credentialing Application. An application for credentialing or recredentialing provided by PCHP to a Provider, and then completed by the Provider, together with all its attachments and attestations.

Credentialing Authorities include the State Agencies that set forth credentialing requirements, NCQA and the Centers for Medicare and Medicaid Services.

Data Bank is the information source regarding Providers maintained by the United States Department of Health and Human Services, which merged the former National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

Delegated Entity. A Delegated Entity is an organization or person to which PCHP has made a delegation of credentialing authority.

DSHS is the Texas Department of State Health Services.

Emergency Care. Emergency Care means health care services provided in a hospital emergency facility or comparable facility needed to evaluate and stabilize an "emergency medical condition," as further defined in the Texas Medicaid Provider Procedures Manual.

Facility is a hospital, ambulatory surgery center or behavioral health center that provides in-patient medical care or residential or out-patient mental health or substance abuse treatment.

Facility Services. Facility Services are surgical and related medical Covered Services for Covered Persons who are not anticipated to require an Admission and/or overnight care and are generally offered to the public by Facility.

Final Decision is PCHP's ultimate decision about whether to terminate a Participating Provider's contract or deny a Provider credentials, made after the Initial Decision, any appeal and the recommendation of the Appeals/Peer Review sub-committee, and its communication of the final termination to the Provider.

HIPAA is the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations, including those regulations related to the privacy and security of a Covered Person's information.

His/Her, Him/Her includes its and their.

Imminent Threat to Patient Safety means a threat that is immediate in time, so severe in nature that the patient is being exposed to an unreasonable risk of death or serious bodily or mental injury, and may only be reasonably mitigated by taking the proposed action.

Initial Decision. PCHP's Initial Decision is its decision to terminate the contract of a Participating Provider or deny credentials to a Provider. If the Provider does not appeal the Initial Decision, the Initial Decision becomes PCHP's Final Decision.

Material Restriction is a loss, suspension or change in professional licensure or certification status, including but not limited to a requirement to obtain a second opinion from another practitioner regarding patient diagnosis or treatment or to have a second person present during any examination or procedure; any limitation on prescribing authority; or (if applicable) any change in hospital staff privileges, including resignation in lieu of discipline or termination, if the Participating Provider normally admits patients to a Facility.

Member Responsibility Amount. The Member Responsibility Amount is any amount set forth by the controlling laws and regulations that the Provider must collect from the Covered Person at the time of providing Covered Services. The amount (if any) should appear on the Covered Person's ID card.

NCQA is the National Committee on Quality Assurance.

Parkland Community Health Plan, Inc. ("PCHP") is the entity licensed by State Agencies that offers State Programs and/or other health plans or programs.

Participating Provider. A facility, Specialist Provider, PCP, Ancillary Services Provider or other person or entity that has a contract with PCHP to provide services or supplies for Covered Persons.

Party/Parties. A Participating Provider and PCHP are each a "Party," and together are the "Parties."

PCHP Administrator. The PCHP Administrator is any third-party vendor retained by PCHP to assist PCHP in performing its responsibilities under the State Programs.

Peer Review is the evaluation of a Quality of Care Issues or Quality of Care Concerns regarding a Participating Provider by other professionals with similar expertise/experience or the review of a Credentialing Application to determine if a Provider should be eligible to become a Participating Provider.

Peer Review Process is the confidential process carried out by fellow Providers to evaluate a Quality of Care Issue or Quality of Care Concern, and to make recommendations to PCHP regarding the subject Provider's status. A flow chart setting forth the process is available at www.parklandhealthplan.com.

Primary Care Provider ("PCP"). A licensed physician who is credentialed as a primary care physician by PCHP to provide and coordinate Covered Services for Covered Persons.

Provider. Any provider of health care services that does not have a contract and/or is not credentialed by PCHP.

Provider Manual. This Provider Manual or Manual is meant to inform the Participating Provider of relevant information, policies, procedures and both Provider's and PCHP's duties under the State Programs and the Parties' agreement. The Provider Manual may be changed from time to time, and the then-current version will be available at www.parklandhealthplan.com.

Provider Quality Assurance Committee is a Committee of Participating Providers and other appointed Providers which will provide support to its sub-committees and provide input to PCHP on medical and business matters facing the Provider Community.

Quality Assurance and Performance Improvement Plan. PCHP's Quality Assurance Plan and Performance Improvement Plan is described in this Provider Manual, and includes its Credentialing and Recredentialing Plan, the quality management, quality improvement, utilization management and care coordination programs, and any other quality-related activities mandated by law.

Quality of Care involves whether Covered Services are provided to Covered Persons in an appropriate and timely manner, including but not limited to the Covered Person obtaining timely access to diagnosis and treatment, proper continuity of care and referrals to specialist care when warranted; whether the Participating Provider's expertise is sufficient to provide a particular Covered Service; whether the environment where the Covered Services are provided is safe; whether the Covered Person does not have material substantive complaints; whether the outcome (e.g., Covered Person's health status, death or disability, prescription/treatment) is reasonable given the Covered Person's medical status; and whether the Covered Services provided are adequately documented.

Quality of Care Issues involve complaints or questions raised by the PCHP Administrator; PCHP staff; Covered Persons; Credentialing Entities; facilities; Participating Providers, providers or others regarding Quality of Care provided by a specifically identified Participating Provider. Quality of Care Issues may be raised either verbally or in writing.

Quality of Care Concerns are Quality of Care Issues where the Medical Director determines that there is an Imminent Threat to Patient Safety or sufficient reason to refer a Quality of Care Issue to a Third-Party Expert for further evaluation. The evaluation of a Quality of Care Concern is to be based on current medical knowledge and standards applicable to the Participating Provider.

Service Area. PCHP's Service Area consists of Dallas, Collin, Rockwall, Kaufman, Navarro, Hunt and Ellis Counties.

Service Issues. Service Issues are raised by a Covered Person or other person which are not Quality of Care Issues or Quality of Care Concerns but requires some action by PCHP staff and/or the State Agencies. Service Issues do not involve a threat to the Covered Person's health or safety. Service Issues include but are not limited to issues related to HIPAA and the Covered Persons and his/her family's confidentiality, privacy and respectful treatment by the Participating Provider and his/her staff. Service Issues may include perceived Quality of Care Issues which does not rise to the level of Quality of Care Concerns.

Specialist Provider. A licensed physician who is credentialed by PCHP as a Specialist to provide specialty Covered Services for Covered Persons (and in some limited circumstances to serve as a PCP when approved to do so by PCHP).

State Agencies. The "State Agencies" are the Texas Department of Insurance ("TDI"); the Texas Department of State Health Services ("DSHS"); the Texas Health and Human Services Commission ("HHSC"); and any other agencies or their agents charged with oversight and/or regulation of the State Programs.

State Licensing Agencies. State Licensing Agencies are those agencies responsible for the licensing/certification and investigation of professional conduct for Facilities, Ancillary Service Providers and Associated Health Professionals

State Programs. The State Programs include the Texas Medicaid Managed Care Program (STAR) and the Texas Children's Health Insurance Program (CHIP) and other programs for low-income persons regulated by the State Agencies and which are offered by PCHP, all of which may be changed from time to time.

Third Party Expert is a physician (or other relevant health care professional) who has expertise regarding the Covered Services at issue in a potential Quality of Care Concern that has been referred by PCHP to the Third-Party Expert for evaluation. The Third-Party Expert may not be in direct economic competition with the Participating Provider about whom a potential Quality of Care Concern is raised.

THSteps. THSteps is Texas Health Steps, also known as Early and Periodic Screening, Diagnosis and Treatment. THSteps is a children's benefit under Texas Medicaid which provides medical and dental preventative care and treatment to Medicaid clients who are birth through 20 years of age.

TMPPM. TMPPM shall mean the Texas Medicaid Provider Procedures Manual available at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Urgent Care is care sought by a Covered Person based on a health condition which does not require Emergency Care but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that his or her condition requires medical evaluation or treatment within 24 hours to prevent serious deterioration to his or her condition or health. Severe vomiting, earaches, sore throats or fever are considered "urgent." Preventive care services and other routine treatment for conditions such as minor colds and flu are not considered "urgent."

Written Notice or Notice. Any Written Notice or Notice required by this Agreement may be given by either of the Parties addressed to the other at the address set forth immediately below the recipient Party's signature to this Agreement and sent by US certified mail, return receipt requested, which is deemed delivered three (3) Business Days from the date sent. Any failure to give Written Notice of a change in the contact address will result in any Written Notice given to the "old" address to be deemed received.

PCHP Duties

PCHP will comply with its contractual obligations and the requirements of the State Programs. In addition, PCHP has the following obligations:

Covered Person Benefits

PCHP provides all benefits covered under the State Programs, as well as some value-added services. If you are unsure whether a particular service or treatment is covered under a Covered Person's plan, please refer to Appendices F and J, call Provider Services, or you may consult the current edition of the TMPPM.

Covered Person Communications

PCHP does not impose restrictions on a PCHP's Medicaid or CHIP providers' free communication with a Covered Person about the Covered Person's medical conditions, treatment options, referral policies, and other policies, including financial incentives or arrangements and all managed care plans with which the network provider contracts.

Termination

PCHP will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Participating Provider.

Plan termination

Physicians and other providers must inform Parkland Community Health in writing of their intent to terminate their participation with us at least 90 days prior to termination from the plan. This information can be sent to:

Parkland Community Health Provider Relations

P.O. Box 569150

Dallas, TX 75356-9150

Fax: 1-866-510-3710

Within 15 calendar Days after receipt or issuance of a termination notification, we will notify 1) all Members in a PCP's panel and 2) all Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months and assist them in selecting new providers or coordinate the transition of care.

Actions to Collect Payment

PCHP will initiate and maintain any action necessary to stop a Participating Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against any State Agency or Covered Person or anyone acting on their behalf to collect payment, excluding payment for non-Covered Services for which there is a properly executed private pay agreement (Appendix O) or for an authorized Member Responsibility Amount.

Participating Provider Qualifications

All Participating Providers must have a contract with PCHP, be credentialed per the PCHP Credentialing Plan, and be eligible to participate in the State Programs.

Primary Care Provider Qualifications

Participating Providers from any of the following practice areas may act as PCP's for Covered Persons: general practice, family practice; internal medicine; pediatrics; obstetrics/gynecology (Ob/Gyn); certified nurse midwives (CNM), pediatric and family advanced practice nurses and physician assistants (PA's) practicing under the supervision of a physician, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or similar community clinics.

With approval by the PCHP Medical Director, Specialist Providers may act as PCP's for designated Covered Persons who are chronically ill or have medically complex or

other special health care needs; these Specialist Providers must comply with the

requirements applicable to PCP's. If you are a Specialist and wish to serve as a PCP for a specific Covered Person, contact PCHP to initiate the process of review.

CHIP and CHIP Perinate Provider Qualifications

A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care Provider that provides prenatal care and is also credentialed by PCHP as a PCP or Specialist.

Specialist Qualifications

A Participating Provider is a "Specialist" if he/she is credentialed as a Specialist by PCHP by virtue of the Provider's education, training, experience and/or certification by relevant professional societies.

Participating Provider Duties Regarding Provision of Covered Services

Role of Primary Care Provider/Medical Home

The Primary Care Provider (PCP) is the cornerstone of Parkland Community Health Plan. The PCP is the medical home for the Covered Person, working with the Covered Person, the Covered Person's family and other Providers to coordinate care that is comprehensive, culturally sensitive and designed to meet the Covered Person's needs. The "medical home" concept should assist in establishing a member and provider relationship and, ultimately, better health outcomes.

PCP's provide all primary care Covered Services within the scope of the PCP's practice, including appropriate health education and instructions to the Covered Person and/or to family Covered Persons or primary caregivers. PCP's also arrange for the provision of Covered Services outside their scope of practice via referrals to other Participating Providers; a link to the referral form is found at Appendix N.

Covered Services are defined, and pertinent coverage limitations and exclusions are described in the TMPPM and at Appendices F and J.

All Covered Persons should receive the following "Routine Services," which are defined as preventative and medically necessary Covered Services within the

scope of the PCP's license, which are not Emergency Care or non-urgent

Covered Services outside of the Dallas Service Area:

- For CHIP Covered Persons under the age of 20, well child health checkups in accordance with the American Academy of Pediatric recommendations.
- For Medicaid Covered Persons under the age of 21, Checkups in accordance with the THSteps periodicity schedule; please consult Appendix M for more details.
- For Medicaid Covered Persons under the age of 21, the Primary Care Provider must either

be enrolled as a Texas Health Steps provider or refer Covered Persons due for a Checkup to a Texas Health Steps provider.

- For adult Covered Persons over the age of 21, adult health care oversight and care based on the recommendations of the U.S. Preventative
- Services Task Force.

PCP's are also required to do the following in connection with providing Covered Services:

- Assess the medical and behavioral health needs of Covered Persons based on the PCP's established procedures. If treatment is needed, the PCP may provide mental health treatment when appropriate to do so, or should make a referral to the Specialty Behavioral Health Providers shown on Appendix A. If the PCP elects to provide mental health Covered Services, the PCP must use the THSteps behavioral health forms and submit completed THSteps screening and evaluation results to the behavioral health vendor at the number shown on the first page of this Provider Manual and at Appendix A .Note: Covered Persons may self-refer to PCHP's behavioral health vendor.
- Obtain pre-authorization from PCHP for those services that require it; a list of services requiring pre-authorization can be found at Appendix N. Claims for services that are not pre-authorized when pre-authorization is required will be denied.
- Make appropriate referrals (except in the case of Emergency Care, referrals to non-Participating Providers required PCHP's prior authorization; the form for referrals is found at Appendix N). Note: Covered Persons do not need PCP referrals for behavioral health, obstetrical/gynecological or family planning care, basic vision care, and for certain Specialists who are Participating Providers, as defined at Appendix N. Claims resulting from Covered Person visits where a referral was not received by the Specialist or other Participating Provider will be denied.
- For Covered Persons with disabilities or chronic or complex conditions, develop a plan of care that meets the special preventative, primary acute care and specialty care needs of the Covered Person based on his/her health needs, Specialist recommendations, and provide periodic reassessments of the Covered Person's status and needs.
- Provide timely follow-up after Out-of-Area Urgent Care, Emergency Care or Admission. Once the attending physician determines that the Covered Person is stable, post-stabilization care should be coordinated by the Primary Care Provider, who must record all pertinent information about the care received and the post-stabilization services in the Covered Person's medical records.
- Coordinate the Covered Person's care, including transfers of medical information between Providers and community support services.
- Work to ensure that family Covered Persons are involved in decision making for their dependents.
- Provide information concerning appropriate support services (*e.g.,* WIC, ECI) within the community. In the case of children and youth with Texas Health Steps benefits; coordinate with existing State Agencies' approved providers and/or case managers within ECI, DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants. DSHS can offer various mental health and mental retardation programs, such as psychiatric treatment, child and adolescent counseling, and crisis intervention.
- Coordinate care for hospitalized Covered Persons, including following:

- *Ensure that pre-admission planning for all non-Emergency Care Admissions is complete prior to the date of admission;
- *Ensure that discharge planning is complete prior to the date of discharge, including confirmation that home and community arrangements are in place if needed to care for the Covered Person.
- Assist in the development of alternatives to hospitalization when medically appropriate.

Role of the Specialty Care Provider

The Specialty Care Provider partners with the PCP to deliver specialty care to members. A key component of the specialist's responsibility is to maintain ongoing communication with the member's PCP.

Specialty care practitioners and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services.

Specialist consultations do not require authorization if the specialist is an in-network provider. Medical specialists are responsible for providing covered health services within the scope of their PCHP agreement and within the scope of their specialty license.

You agree to render covered health services to members in the same manner as offered to other patients, in compliance with State regulations and as described within this provider manual. It is the responsibility of the specialist to report back to the PCP the specialist's findings, recommendations and treatments.

Specialists and other Participating Providers must provide the following Covered Services and related assistance to Covered Persons:

- Provide Covered Services within the scope of the Provider's license, specialization and/or certification.
- Assess the medical and behavioral health needs of Covered Persons for referral to Specialty Behavioral Health Providers when warranted.
- Obtain pre-authorization from PCHP for those services that require it; a list of services requiring pre-authorization can be found at Appendix N. Claims for services that are not pre-authorized when pre-authorization is required will be denied.
- Receive from PCP's and making appropriate referrals (except in the case of Emergency Care, referrals to non-Participating Providers required PCHP's prior authorization; the form for referrals is found at Appendix N). Claims resulting from Covered Person visits where a referral was not received by the Specialist or other Participating Provider will be denied. Note: Covered Persons do not need PCP referrals for behavioral health, obstetrical/gynecological or family planning care, basic vision care, and for certain Specialists who are Participating Providers, as defined at Appendix N.
    - Coordinate the Covered Person's care with the PCP, including transfers of medical information regarding the Covered Person's status, the Specialist's recommendations and course of treatment.

- Work to ensure that family Covered Persons are involved in decision making for their dependents.
    - Provide information concerning appropriate support services (for example, WIC, ECI, etc.) within the community. In the case of children and youth with Texas Health Steps benefits, coordinate with existing State Agencies' approved providers and/or case managers within ECI, DARS, TCB, SHARS the DSHS targeted case management program for high risk pregnant women and infants, and hospice through Department of Aging and Disability Services.
- Coordinate care for hospitalized Covered Persons, including ensuring that:
    - pre-admission planning for all non-Emergency Care Admissions is complete prior to the date of admission; discharge planning is complete prior to the date of discharge, including confirmation that home and community arrangements are in place if needed to care for the Covered Person.
- Assist in the development of alternatives to hospitalization when medically appropriate.

Role of CHIP Perinate Provider

A CHIP perinatal provider provides care for the unborn child. CHIP perinatal members (pregnant women) are not required to select a PCP and 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.

Benefits provided are limited to services that affect the health of the unborn child.

Perinatal Providers provide Covered Services related to the Covered Person's pre-natal visits, labor and delivery. They may also be responsible for providing Covered Services as a PCP or Specialist. They must also provide information concerning appropriate support services (for example, WIC, ECI, etc.) and the DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants, where appropriate.

Role of Pharmacy

PCHP is sub-contracted with a Pharmacy Benefits Manager (PBM) to provide prescription drugs to our members. The PBM for PCHP 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 PCHP formulary.

- Pharmacy providers are responsible for but not limited to:
- Filling prescriptions in accordance with the benefit design.
- Adhering to the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL).
- Coordinating with the prescribing physician.
- Ensuring members receive all medication for which they are eligible.
- Coordinating benefits when a member also receives Medicare Part D services or other insurance benefits.
- Providing a 72-hour emergency supply of prescribed medication when a prior authorization (PA) cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency. Emergency situations include cases in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72-hour emergency supplies on a routine basis.

For any questions regarding formulary, or anything regarding prescription drug coverage, contact us at the Provider Services number at the

bottom of this page.

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.

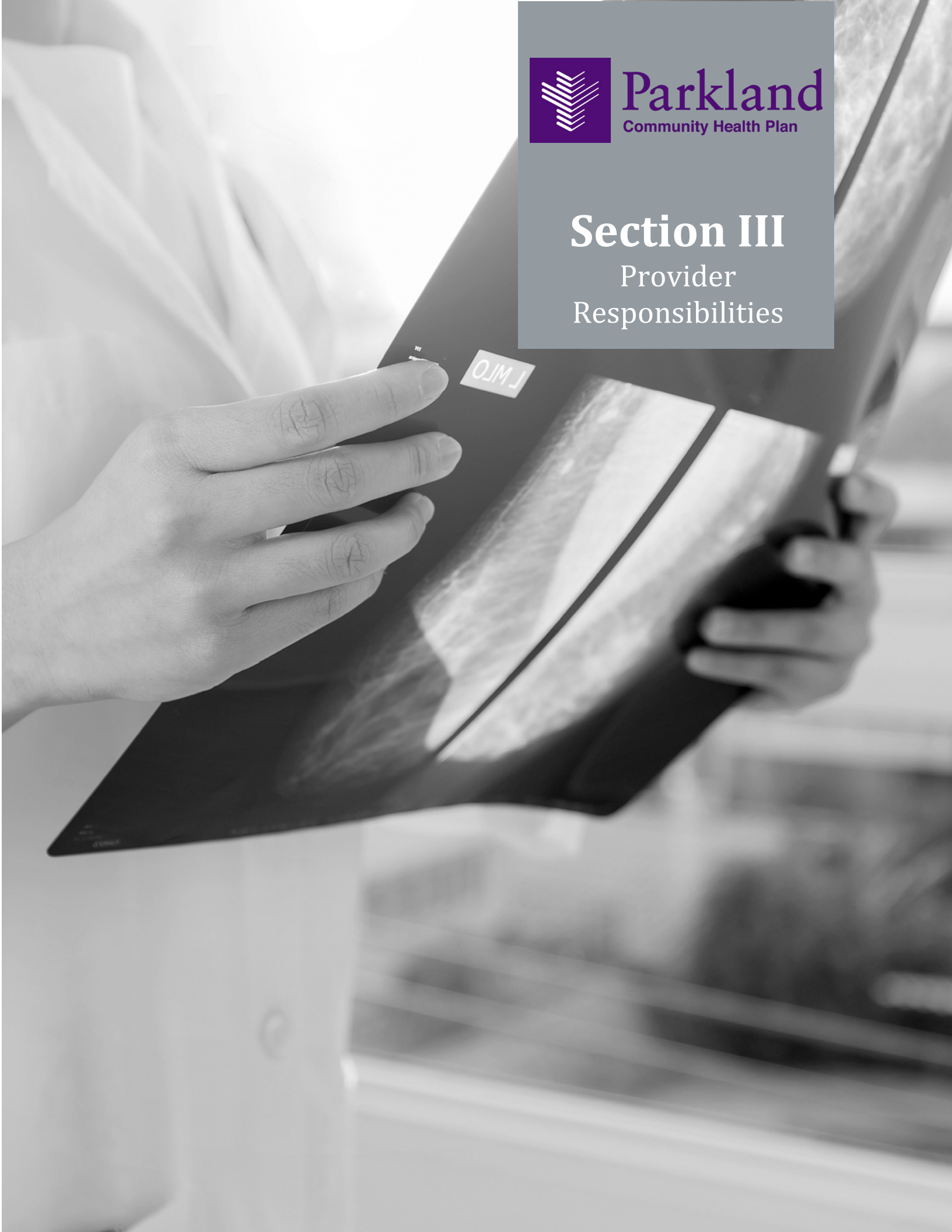
Network Limitations (e.g. Primary Care Providers (PCPs), Specialty Care Physicians, and OB/GYNs)

We have an open provider network for all Parkland Community Health Medicaid and CHIP Members. We do limit a Member's selection of a primary care provider or a referral to a specialist to the Parkland Community Health Medicaid and CHIP networks.

Provider Enrollment in PCHP Medicaid Managed Care Programs

Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by PCHP Health Plan. To be reimbursed for services rendered to PCHP Medicaid Managed Care clients, Providers must be enrolled in Texas Medicaid and then must enroll with PCHP to be eligible for reimbursement for covered services rendered. All Providers joining existing groups should enroll in Texas Medicaid and then submit a credentialing application to PCHP to be credentialed and added as a contracted provider upon approval by the PCHP 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 Parkland Community Health Plan.*



Parkland
Community Health Plan

Section III

Provider Responsibilities

The Role and Responsibilities of the PCP

The PCP plays an integral role in helping us meet the objectives of our health plan. PCHP places its main focus on the total well-being of our Members while providing a "medical home". The PCP is responsible for all provisions of primary care, including preventive health services, in accordance with the STAR/CHIP programs. In addition, the PCP is responsible for coordinating care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. The PCP is responsible for teaching our members and members family how to use available health services appropriately. Each PCHP CHIP and STAR 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:

- Routine and preventive health care services, including immunizations
- Emergency care services •Hospital services
- Ancillary services
- Specialty referrals
- Interpreter services
- Coordination and continuity of care for members
- Case coordination and enhanced services for children with special health-care needs and children with disabilities

PCPs also coordinate care with clinic services, such as therapeutic, rehabilitative or palliative services for outpatients. PCPs must cooperate with any court-ordered services.

Note: The screening provider is responsible for administration of immunizations and should not refer children to local health departments to receive immunizations. PCPs can offer behavioral health services when:

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

Mental Health and Substance Use Disorder

PCHP's Behavioral Health Providers and PCP collaborate with PCHP to ensure 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 PCHP network provider types are eligible to serve as a Primary Care Provider (PCP) for CHIP and STAR 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 PCHP, 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

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

Pregnant Women

Parkland Community Health allows pregnant members past the 24th week of pregnancy to remain under the care

of their current OB/GYN through the Member's postpartum checkup, even if the provider is out-of-network. She may select an OB/GYN within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

Member moves out-of-service area

Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish Members with copies of their medical records.

Pre-existing condition

Parkland Community Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible Member beginning on the Member's date of enrollment into the PCPH Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to Members who are in an "active course of treatment" at the time of enrollment until the Member's records, clinical information and care can be transferred to a network provider or until such time the Member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Out-of-network care will be coordinated for Members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until they are no longer enrolled in the plan.

"Active Course of Treatment" is defined as:

- A planned program of services rendered by a physician, behavioral health provider or DME provider
- Starts on the date a provider first renders a service to correct or treat the diagnosed condition, and
- Covers a defined number of services or period of treatment
- Allowing a pregnant woman to remain under the Member's current Ob/Gyn care through the Member's post-partum checkup even if the Ob/Gyn provider is, or becomes, out-of-network
    - In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met. The Member must:
        - Be enrolling as a new Member, and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider
        - Have initiated an "active course of

treatment" prior to the initial enrollment date.

- If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new Plan level. PCPH's Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.

In order for a nonparticipating provider to continue treating Plan Members during a transition period, the provider must agree to:

- Continue to provide the Member's treatment and follow-up
- Accept Plan rates and/or fee schedules
- Share information regarding the treatment plan with the Plan
- Use the Plan network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.

Members Right to Designate an OB/GYN

Parkland Community Health allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

Attention female members:

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

OB/GYN Responsibilities

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

- Telephoning or faxing Case Management with the required information.
- Notifying Department for CHIP/STAR Members or Service Coordination.
- Conduct a post-partum visit between the 21st and the 56th day of delivery.

Other Specialty Care Physicians as Primary Care Provider (PCP)

Members with disabilities, special health care needs, and or Chronic or Complex conditions, have the right to designate a specialist as their Primary Care Provider if the specialist agrees. Specialist physicians or other professional providers acting as a PCP must follow all responsibilities of a PCP.

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

Accessibility Standards

Primary Care Providers (PCPs) and Specialty Care Physicians must be available to Members 24 hours a day, seven days a week, either directly or through the provider's delegate. The delegate for the provider must be credentialed by PCHP to provide services for the Primary Care Provider (PCP) or Specialty Care Physician.

Appointment Standards

Each PCP shall provide covered services at their offices during normal business hours and be accessible to Covered Persons 24 hours per day, 7 days per week. The PCP shall arrange for appropriate coverage with other Participating Providers if he/she is unavailable due to vacation, illness, or leave of absence. PCP's must be accessible to Covered Persons 24 hours a day, 7 days a week, via one of the following methods: (1) office phone answered by answering service, with calls returned by PCP within 30 minutes; (2) office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP's or another Participating Provider's direct number, which must be answered (referring the Covered Person to another recording is not acceptable); (3) office phone transferred to another location that answers and contacts the PCP or another designated Participating Provider, with the call to be returned within 30 minutes. PCP's may not have a phone message that directs the Covered Person to simply leave a message or to go to the emergency room for any service needed, although direction to go to the emergency room for Emergency Care is appropriate.

The following are the established PCHP access standards for PCPs and Specialty Providers:

Primary Care Providers (PCPs) must make appointments available to Members as follows:

Appointment Type	Standard
New Covered Person • Newborn • Children • Adult	New Covered Persons should be offered appointments as soon as possible after enrollment but in no case later than within: • 14 calendar Days of enrollment for newborns • 60 calendar Days of enrollment for all other Covered Persons
Preventive Care • Newborns • Children < 21 • Adult > 21	**For CHIP** - Physicals/Well-child checkups for As soon as possible for Covered Persons who are due or overdue for services in accordance the AAP guidelines **For Medicaid** – Covered Persons under the age of 21, per THSteps Periodicity Schedule, but in no case later than 60 days from date of request. For all newly enrolled Covered Persons (Medicaid and CHIP), appointments must be offered within • 14 days of enrollment for newborns; • 60 days for all others.
Routine Primary Care	Within 14 calendar Days of request.
Urgent Care	Within 24 hours of request
Emergency Care	Upon presentation
Prenatal Care	Within 14 calendar Days of request, except for high risk pregnancies or new Covered Persons in the third trimester for whom an appointment must be offered within 5 calendar Days, or immediately, if an emergency exists
Initial Behavioral Health Care	Within 14 calendar Days of request
After-hours care	For PCPs: practitioners must be accessible 24/7 directly or through answering service • Answering service or recording assistance in English and Spanish • Member reaches on-call physician or medical staff within 30 minutes

Specialty Care Providers Access and Availability Requirements:

Appointment Type	Standard
Routine Medical Care	Within 14 calendar Days of request
Urgent Medical Care	Within 24 hours of request
Emergency Care	Upon presentation
Prenatal Care	Within 14 calendar Days of request, except for high risk pregnancies or Covered Persons in the third trimester for whom an appointment must be offered within 5 calendar Days, or immediately, if an emergency exists
Prenatal care: high-risk or third trimester – initial visit	Within five days or immediately, if an emergency exists
Behavioral health: non-life-threatening emergency	Within six hours (NCQA)
Behavioral health: urgent care	Within 24 hours
Post hospital discharge (behavioral health)	Within seven days of discharge (for missed appointments, provider must contact member within 24 hours to reschedule)
Initial Behavioral Health Care – routine care	Within 14 calendar Days of request
Behavioral health: routine care – follow-up visits	Within three weeks

Primary Care Provider (PCP) Referrals to Other Providers

Primary Care Provider (PCP) Referrals to Network Providers

The Primary Care Provider is responsible to refer PCHP Members to Specialty Care Physicians or other ancillary providers for medically necessary services. The PCP will make referrals for specialty care for members on a timely basis based on the urgency of the member's medical condition, but within no later than 30 calendar Days from the date the need is identified or requested.

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

If a required service is not available within the Parkland Community Health Medicaid or CHIP network, the Member's primary care provider may request an out-of-network referral. However, the primary care provider must obtain authorization from the Parkland Community Health Medical Management Department.

The steps for an out-of-network referral are as follows:

1. The Member's Primary Care Provider must complete a referral request and specify the services required of the out-of-network provider including the rationale for requesting out-of-network services.
2. The Primary Care Provider can call Medical Management or fax the referral form and all pertinent clinical information to the Parkland Community Health Medical
3. Management Department by calling 1-800-306-8612 or faxing 1800-240-0410 to obtain authorization.
4. The Primary Care Provider will provide authorization information to the specialist.

The out-of-network referral is valid for 90 days for a maximum of three visits unless otherwise authorized by the Medical Management Department. A new authorization must be obtained if the original authorization is over 60 days old or if more than two visits are required, unless additional visits have been authorized by the medical management department.

Telemedicine, Telehealth, and Telemonitoring Access

We encourage our network providers to offer telemedicine, telehealth and telemonitoring capabilities to our members. Information will be included in our provider directories as to which providers have these services available.

School-based telemedicine medical services are a covered service for members. We will reimburse the distant site physician providing treatment even if the physician is not the patient's PCP or is an out-of-network physician. Prior authorization is not required for school-based telemedicine medical services.

Members Right to Self-Referral

PCHP 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 (Mental health and substance use disorder)
- Emergency room care
- Obstetric services
- Well-woman gynecological services
- Vision care, including covered eyeglasses
- A network Ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery

Responsibilities of Specialty Care Physicians

Specialist providers will only treat members who have been referred to them by network primary care providers. The exceptions are mental health and substance abuse providers, and services for which a member may self-refer. These providers will render covered services only to the extent and duration indicated on the referral. Obligations of specialists include:

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

The specialist shall:

- Manage the medical and health care needs of members (including those engaged on a FFS basis) to encompass:
- Monitoring and following up on care provided by other providers
- Coordinating referrals to other specialists and FFS providers (both in and out-of-network)
- Maintaining a medical record of all services rendered by the specialist and other providers
- Provide coverage 24 hours a day, 7 days a week and maintain regular hours of operation that are clearly defined and communicated to members
- Provide services ethically and legally and in a culturally competent manner that meets the unique needs of members with special health care requirements
- Participate in PCHP systems that facilitate record sharing, subject to applicable confidentiality and HIPAA requirements
- Participate in and cooperate with PCHP in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by PCHP
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to consumers
- Participate in and cooperate with the PCHP complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist
- Not balance bill members
  - Continue care in progress during and after termination of his or her contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members; this is to occur in accordance with applicable state laws and regulations

- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to his or her practice location
- Support, cooperate and comply with PCHP quality improvement program initiatives, and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner
- Inform PCHP if a member objects for religious reasons to the provision of any counseling, treatment or referral services
- Treat all members with respect, dignity and appropriate privacy; treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations
- Provide members complete information concerning diagnosis, evaluation, treatment and prognosis; give members the opportunity to participate in decisions involving health care, except when contraindicated for medical reasons
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program; advise members on treatments that may be self-administered
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Establish and maintain a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies and poison control centers to provide quality patient care
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care
- Within 30 days of occurrence, provide written notice to PCHP if the specialist is named as a party in any civil, criminal or administrative proceeding; failure to provide timely notice to PCHP constitutes grounds for termination of the specialist's contract with PCHP
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101

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

Marketing Guidelines Affecting Providers

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

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

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Medical Records

Providers shall keep Members' medical records confidential in compliance with State and federal laws regarding confidentiality of medical records. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. However, nothing shall limit timely dissemination of such records to authorized providers and consulting physicians, to governmental agencies as required and permitted by law, to accrediting bodies, to committees of provider, and to PCHP for administrative purposes. To the extent permitted by law, PCHP shall have the right to inspect at all reasonable times any medical records maintained by provider pertaining to PCHP Members. A provider agrees to maintain all medical records pertaining to treatment of Members for a period of ten (10) years or, for minors, ten years past the attainment of age 21 years.

Medical Records shall not be removed or transferred from a provider except in accordance with general provider policies, rules, and regulations. Providers agree to furnish Members timely access to their own records. PCHP may audit a provider's medical records for PCHP Members, as a component of PCHP's quality improvement, credentialing, and re-credentialing processes. In accordance with AMA guidance and NCQA guidelines, medical records must be legible with current details organized and comprehensive in order to facilitate the assessment of the appropriateness of care rendered. Documentation audits are performed to assure that PCPs and high-volume Specialty Care Providers maintain a medical record system that permits prompt retrieval of information. Audits are also performed to assure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to health care providers. Medical record review also provides a mechanism for assessing the appropriateness and continuity of health care services. Applicable regulations mandate medical record review by PCHP. Criteria (indicators) to be evaluated include the following:

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

Documentation of each visit must include the following:

- Date of service
- Complaint or purpose of visit
- Diagnosis or medical impression
- Objective finding
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimens
- Medications prescribed
- Health education provided
- Signature or initials and title of the provider rendering the service

Note: If more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.

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

- **Patient identification information:** Each page or electronic file in the record must contain the patient's name or patient ID number.
- **Personal/biographical data**: The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
- **Date and corroboration**: All entries must be dated and author-identified.
- **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies – NKA) must be noted in an easily recognizable location.

- **Past medical history for patients seen three or more times**: Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, the history must include prenatal care of the mother and birth.
- **Physical examination:** A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
- **Immunizations:** For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.
- **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.
- **Medication information:** This notation includes medication information and instruction(s) to the patient.
- **Identification of current problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
- **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.
- **Smoking/alcohol/substance abuse:** A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
- **Preventive services/risk screening:** The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.

- **Consultations, referrals and specialist reports:** Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
- **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
- **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
- **Advance directive:** Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision-making for individuals who are incapacitated.
- **Security:** Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
- **Release of information:** Written procedures are required for the release of information and obtaining consent for treatment.
- **Documentation:** Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.
- **Multidisciplinary teams:** Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
- **Integration of clinical care:** Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:
  - Notation of screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
  - Notation of screening and referral by behavioral health providers to PCPs when appropriate
  - Notation of receipt of behavioral health referrals from physical medicine providers and the disposition and outcome of those referrals
  - A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the PCP
- A written release of information that will permit specific information sharing between providers
- Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, has a co-occurring behavioral disorder

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

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

Within 10 days of a change in address or contact information, network providers must inform Parkland Community Health Plan and HHSC's administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:

- The production of an accurate provider directory
- The support of an accurate online provider lookup function
- The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member's PCP
- The guarantee of accurate claim payment delivery information

Provider Configuration PCHP
1341 West Mockingbird Lane, Suite 400E
Dallas, Texas 75247

Cultural Sensitivity

Texas Medicaid & CHIP recipients will vary in language and culture (*e.g.,* customs, religion, backgrounds). Participating Providers must provide Covered Services to all Covered Persons in a manner that recognizes and respects the worth and dignity of each Covered Person, including providing simplified explanations for those with limited comprehension. For additional information, there is a free online provider education course on cultural competency at www.txhealthsteps.com. Note: The material included in the module is applicable to all Covered Persons, not just those receiving Medicaid or THSteps services.

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 PCHP network. If a provider desires to terminate his/her participation agreement with PCHP, a written notice to PCHP 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 PCHP. PCHP 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.

PCHP Requested Termination

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

Appeal of Termination or Denial of Credentials

If PCHP terminates the Parties' Agreement or denies the Provider's Credentialing Application, the Provider may appeal this Initial Decision.

The Initial Decision will be reviewed by the Peer Review and Appeals Sub-Committee, which will consist of Participating Providers and other Providers as required to meet the State Agencies' "non-competitor" and "same specialty" rules. The Provider who appeals may present evidence that he/she believes is relevant to the termination/denial of credentials. After consideration of the information presented, the Peer Review and Appeals Sub-Committee will make its recommendation that the Initial Decision be upheld or overturned.

PCHP will make a Final Decision about the Provider's status and communicate that to the Provider within the time required by law. If the Provider is dissatisfied with the Final Decision, the Provider must resolve any dispute through the Dispute Resolution Process described in this Provider Manual.

Notification of Covered Persons

PCHP will notify all Covered Persons in a PCP's panel and all Covered Persons who have had two or more visits with the Participating Provider for home-based or office-based care in the past 12 months of the termination as required by law.

Cooperation in Transition

The Provider must cooperate in assisting PCHP and the Covered Person with the transition of care to a new Participating Provider.

Provision of Continuing Treatment Post-termination

Participating Providers are obligated to continue to provide certain Covered Services even after termination of their contract with PCHP, and PCHP is required to pay for that treatment at the contracted rates. Examples include:

- **Medically fragile or terminal Covered Persons**. Covered Persons whose health or behavioral health condition has been treated by Specialty Participating Providers; who have a terminal condition; or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted shall remain under the care of a formerly Participating Provider until an appropriate transition of care can take place.
- **Late Pregnancy**. Covered Persons past the 24th week of pregnancy (16 weeks or less until the expected delivery date) will be allowed to remain under the care of their current Obstetrician/Gynecologist through the post-partum checkup or may select another Participating Provider.

Payment for Covered Services Post-termination

In order to obtain payment for this continuing treatment, the Provider must obtain PCHP's pre-authorization when required by Appendix N and cooperate with PCHP's Case Management regarding the Covered Person's course of treatment. Payment for continuing treatment will be at the previously contracted rate.

Member Materials

All PCHP Member materials and website content are specially designed to take into consideration the population's needs. Materials are intended to be user-friendly and concise and they are written at a reading level that is at or below 6th grade.

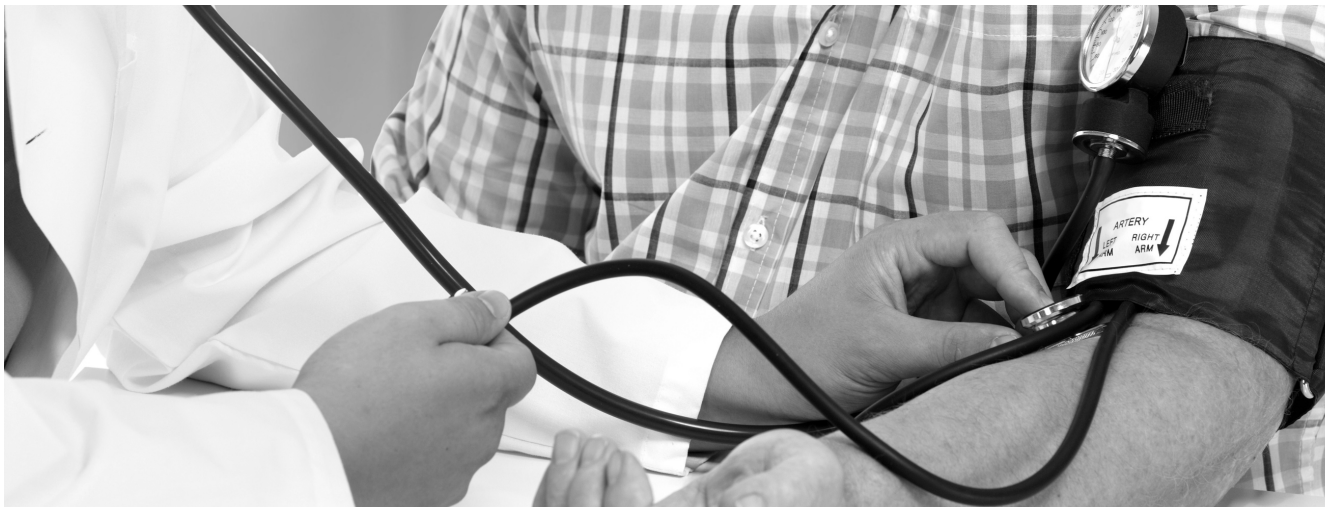
Providers are encouraged to provide patient notices and general information about their practice in a similar form to ensure that patients understand the information. All Member materials regarding advance directives are written at a 7th - 8th grade reading comprehension level, except where a provision is required by State or federal law and the provision cannot be reduced or modified to a 7th – 8th grade reading level because it is a reference to the law or is required to be included "as written" in the State or federal law.

Community First Choice

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).

- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all 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.



Compliance and Privacy

Compliance with State and Federal Laws.

Participating Providers must comply with the currently effective version of all state and federal rules, including but not limited to the following:

1. Environmental protection laws: Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
   a. National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
   b. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
   c. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
   d. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;
2. State and federal anti-discrimination laws:
   e. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
   f. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
   g. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
   h. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
   i. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
   j. Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);
   k. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16;
   l. The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.
3. The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments;
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and
5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et. seq.

HIPAA Incident Reporting

Protected Health Information (PHI) HIPAA Incident Reporting

Providers and facilities are required to review all member information received from PCHP to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at 888-672-2277 for STAR program and 888-814-2352 for CHIP for help.

Fraud Information

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE AND CHIP

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

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Parkland Community Health Plan
Compliance Officer
ATTN: Nakia Smith, VP Health Plan Compliance
1341 W. Mockingbird Lane
Suite 400E
Dallas, TX 75247
(214) 266-2130

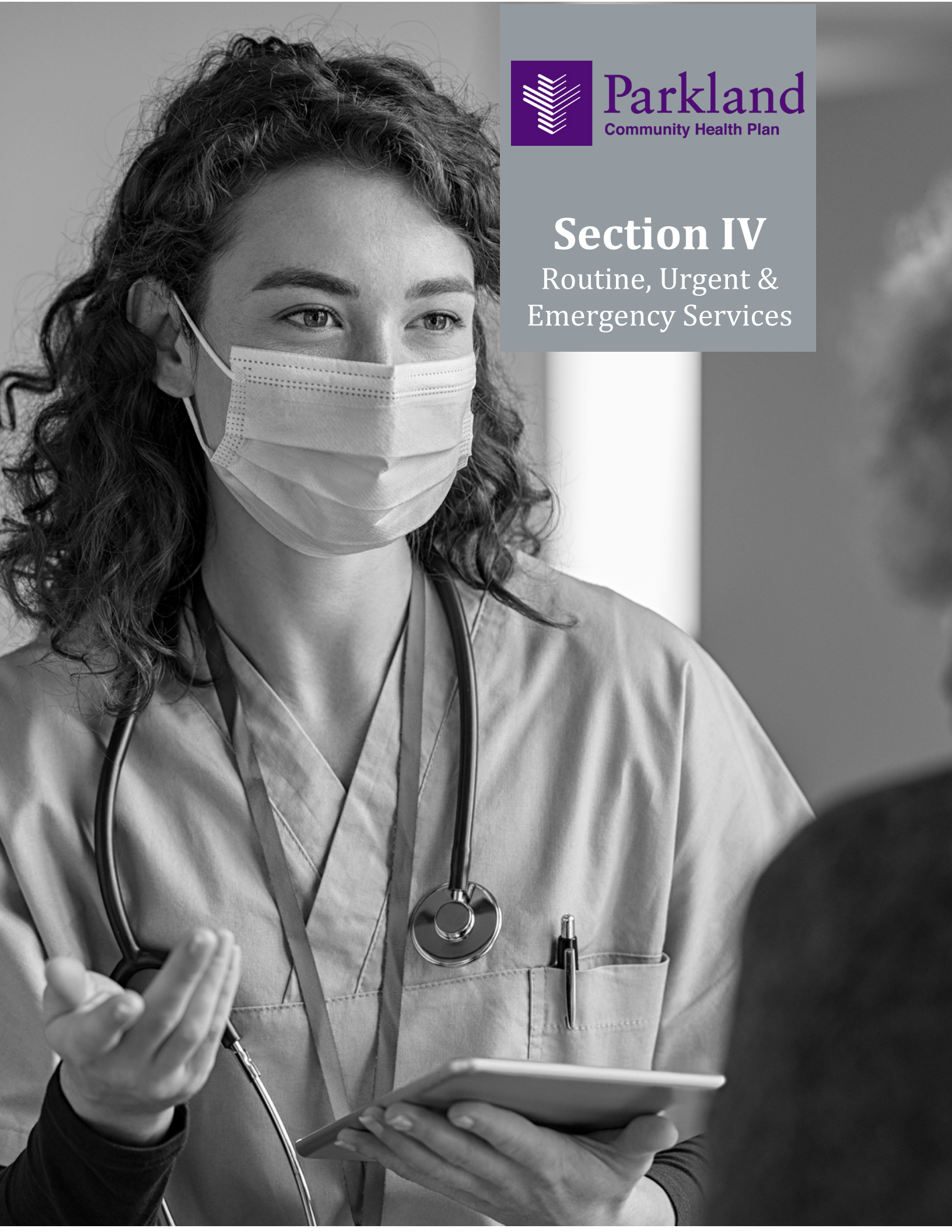
To report waste, abuse or fraud, gather as much information as possible.

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

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

When reporting about someone who 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



Parkland
Community Health Plan

Section IV

Routine, Urgent & Emergency Services

Definitions: Routine, Urgent and Emergent Services

Routine

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

Urgent Condition

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

Emergency Medical Condition

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

(1) placing the Member's health in serious jeopardy;
(2) serious impairment to bodily functions;
(3) serious dysfunction of any bodily organ or part;
(4) serious disfigurement; or
(5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Services

Emergency Services 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 an Emergency Behavioral Health Condition, including Post-stabilization Care Services. Emergency care is covered for PCHP Members twenty-four (24) hours a day, seven (7) days a week. Prior authorization is not required for Emergency Services.

Emergency Behavioral Health Services

Emergency Behavioral Health means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or (2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

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 a 72-hour emergency prescription supply, pharmacies should submit the following information:

Please contact Navitus at 877-908-6023 (phone) or 855-668-8553 (fax). for more information about the 72-hour emergency prescription supply policy.

Out-of-Network Emergency Services

Out-of-network emergency services are covered by PCHP. 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. The Member Service Department is also available to assist members in locating a provider if they have moved and their change in coverage has not been updated.

Emergency Transportation

When the Member's condition is life-threatening and trained attendants must use special equipment, life support systems or close monitoring while in route to the nearest appropriate facility, the ambulance transport is deemed an emergency service.

Parkland
Community Health Plan

Section V

Behavioral Health Services

Behavioral Health Services

Parkland Community Health Plan has contracted with, and will work in partnership with, Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, to manage the delivery of mental health and substance use disorder services for the Children's Health Insurance Program (CHIP) and the Medicaid State of Texas Access Reform (STAR) program.

Beacon defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. For Medicaid eligible members, these services are administered through a State-contracted vendor (Beacon Health Options).

PCP's may offer behavioral health treatment to PCHP members within the scope of their practice and may also make appropriate referrals to Behavioral Health Specialists. Beacon will provide PCP's with assessment instruments for use in providing Behavioral Health services.

Providers must use DSM-V multi-axial classifications and other assessment instruments, or outcome measures required by HHSC when assessing PCHP members for behavioral health services.

Parkland CHIP members can also self-refer to a participating Behavioral Health specialist by calling the vendor listed on Appendix A of this Provider Manual or call Member Services at 1-888-814-2352 and ask for the Health Services Department for assistance.

A PCP or other Specialist and a Behavioral Health Specialist should talk often regarding the health care services provided to each eligible member.

Participating Providers must comply with the Beacon Behavioral Health Clinical Practice Guidelines

Visit Beacon Health Options where you will find a dedicated Behavioral Health Provider Manual.

Behavioral Health Covered Services

Behavioral health services that are offered to CHIP and STAR members are:

Covered Behavioral Health Services

A wide range of mental health and substance use services are available, such as

- Inpatient mental health services including partial hospitalization
- Attention Deficit Hyperactivity Disorder (ADHD)
  - ADHD covered services eligible for reimbursement include: outpatient counseling services for the management of ADHD symptoms to include coping skills, psychoeducation, etc. Medication management with psychiatric prescribers is also covered.
  - Primary care providers should have a strategy for diagnosing and long-term management of ADHD. Providers can discuss the efficacy of using medication to manage an ADHD diagnosis with their patients. Follow up appointments should be made at least monthly until the child's symptoms have been stabilized. Once a child is stable, AAP guidelines recommend an office visit every 3 to 6 months to assess learning and behavior.
- Substance Use Disorder Treatment including assessment, withdrawal management, residential treatment, and outpatient services.
- Therapy - individual, family, and group.
- Psychological & Neuropsychological testing
- Mental Health Targeted Case Management and Rehabilitative Services
- Medication Management and Education

Behavioral health services that are offered to STAR members are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided
- The most appropriate level or supply of service that can safely be provided
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered
- Not experimental or investigative, and not primarily for the convenience of the member or provider

Other elements of members receiving behavioral health services are:

- Member may self-refer to any network behavioral health provider.
- Member has the right to obtain medication from any network pharmacy.
- A primary care provider may refer a member to a behavioral health provider.
- There will be coordination between behavioral health and physical health services.
- Member has the right to obtain a second opinion; medical records and referral information must be documented using the DSM-V multi-axial classification.
- An authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient or guardian prior to receiving care from a behavioral health provider.

- Members under the age of 21 will be provided inpatient psychiatric services, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction.
- Coordination will be conducted with the LMHA and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.
- Assessment documents for behavioral health will be made available for the use of primary care providers.
- Beacon and PCHP will work together to ensure that quality behavioral health services are provided to all members. This coordination will include focus studies and utilization management reporting.
- Provider will contact the member within 24 hours of a missed appointment for the purposes of re-scheduling.
- Members who are discharged from an inpatient psychiatric facility will have a follow-up appointment within seven days from the date of discharge by the provider.

Member Access to Behavioral Health Services

Self-Referral

Eligible members may self-refer to a participating behavioral specialist or participating behavioral health facility. Referral assistance is available 24 hours per day, 7 days per week by calling the Parkland Community Health Texas hotline. Members may also use the provider search tool on the Parkland Community Health Texas website at www.parklandhealthplan.com . Members do not need a referral from their PCP for mental health or substance use disorder services.

Referral Information

Members must obtain care from Beacon Health a participating provider to obtain behavioral health services. Contact us online at www.beaconhealthoptions.com or by phone at 1-800-888-3944. Providers must use DSM-V multi-axial classifications and other assessment instruments, or outcome measures required by HHSC when assessing Members for behavioral health 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.

Focus Studies and Utilization Reporting Requirements

PCHP, along with Beacon, has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to PCHP members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member's overall care. PCHP and Beacon will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

Members Discharged from Inpatient Psychiatric Facilities

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Beacon providers will follow up with Medicaid members and attempt to reschedule missed appointments.

Consent for Disclosure of Information

Members are encouraged to share information about their other health care providers during their initial visit. This will promote communication and collaboration between their health care providers, such as primary care, behavioral health (mental health/substance use disorder), and long-term services and supports. The member's consent is required to release verbal and/ or written information from their health record. Providers may use the "Authorization to Release Protected Health Information Form," which is available on the Parkland Community Health Texas website www.parklandhealthplan.com.

Coordination of Care

Behavioral health service providers are expected to communicate at least quarterly and more frequently if necessary, regarding the care provided to each member with other behavioral health service providers and PCP's.

Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. Copies of prior

authorization/referral forms and other relevant communication between providers should be maintained in both providers' files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care. Compliance with this coordination is reviewed closely during site visits for credentialing and recredentialing, as well as during quality improvement and utilization management reviews.

Coordination between Physical and Behavioral Health

Beacon is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities. Beacon will designate behavioral health liaison personnel to facilitate coordination of care and case management efforts.

Coordination with the Local Behavioral Health Authority

Beacon will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to the state psychiatric facility. Beacon will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether they are receiving targeted case management (TCM) or rehabilitative services through the LMHA.

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

Providers 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

Recognition of abuse and neglect, and appropriate referral to DFPS

Schedule appointments within 14 days unless requested earlier by DFPS

Coordination with Non-CHIP and Non-Medicaid Managed Care Covered Services

PCHP coordinates Non-capitated services with the involvement of community organizations that do not provide covered services but are important to the health and wellbeing of our Members. PCHP will make its best effort to establish relationships with State and local programs and community organizations in order to make referrals for our Members.

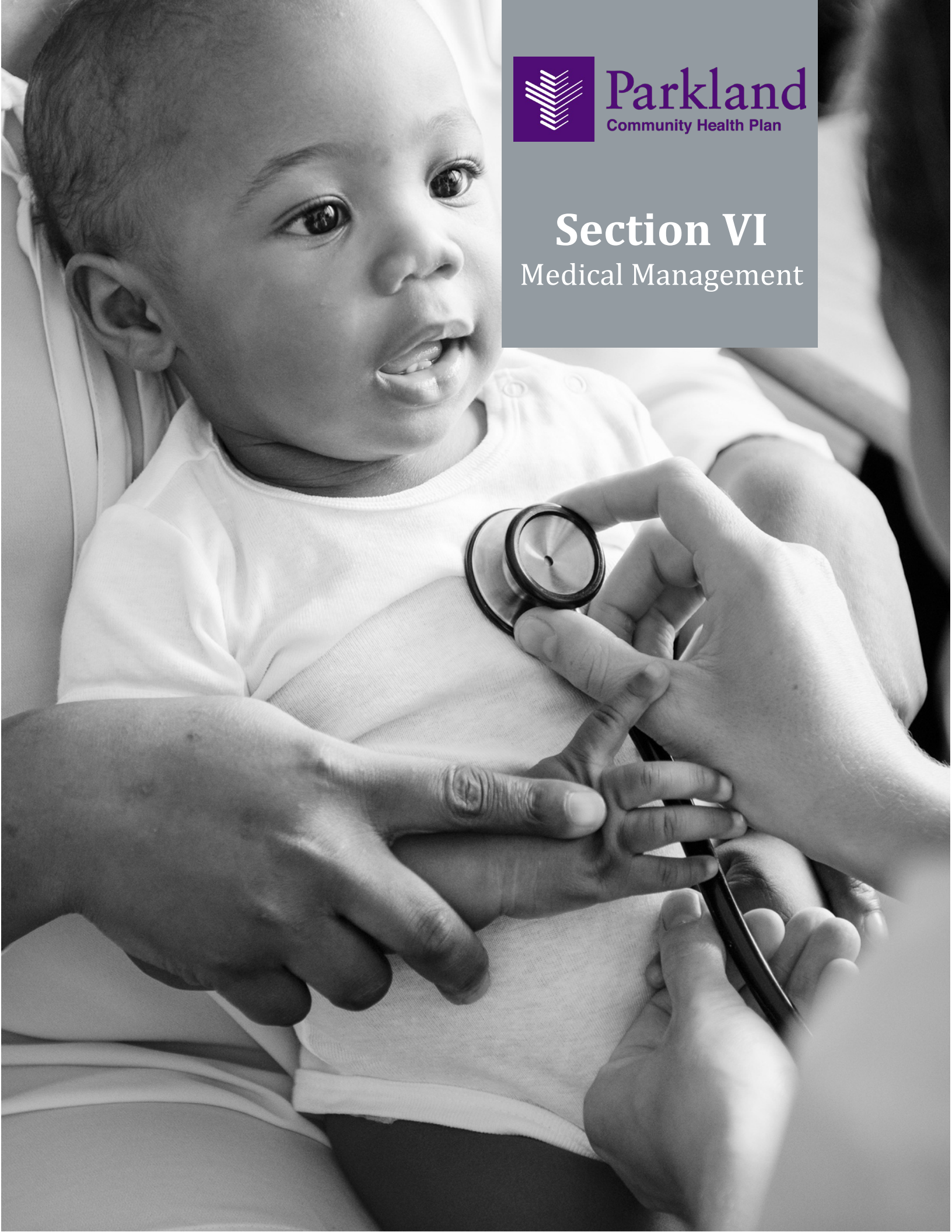
There are other services that are available to PCHP/Beacon members, which may not be accessible through the PCHP/Beacon network. The services listed below are available and accessible to members outside of the PCHP/Beacon network.

- Primary and preventative dental services
- Texas agency-administered programs and case management services
- Essential public health services
- School Health and Related Services (SHARS)
- Early childhood intervention case management/services coordination
- Case management for children and pregnant women
- Texas Health Steps medical case management
- Texas Commission for the Blind case management

- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Medical transportation services available through the Texas Health and Human Services Commission for STAR members only
- Environmental Lead Investigation (ELI) – Lead Screening and Testing

Court-Ordered Services

A "Court-Ordered Commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Beacon is required to provide inpatient psychiatric services to members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court -Ordered Commitments to psychiatric facilities. Beacon will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court -Ordered Commitment for members under age 21.



Parkland
Community Health Plan

Section VI
Medical Management

Utilization Management Program

Utilization Management(UM) collaborates with providers to promote and document the appropriate use of health Care resources. We follow established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, Centers for Medicare & Medicaid (CMS) requirements as well as the Texas Medicaid Provider Procedure Manual are used when determining eligibility for coverage and supersede any other utilization management criteria.

Utilization Management takes a multidisciplinary approach to help provide access to health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

Authorization is based on medical necessity and will be contingent upon eligibility and benefits. It is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications with the exception of Texas Health Steps Service for children from birth through 20 years of age. For these services, medical necessity is based on the clinical documentation received by the utilization management department when requesting a prior authorization.

Authorization Process

When requesting an authorization or to notify of a patient admission, please have available the Tax Identification Number (TIN) and National Provider Identifier (NPI) that you will use to bill your claim. If you do not include your identifiers, your request will not be processed. It will be very important that the numbers you use to request your authorization match the numbers you will use to bill your claim, or your claim will deny. If you have any questions about this requirement, you can call the Provider Services hotline, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time at 888-672-2277 for STAR program and 888-814-2352 for CHIP

How to find a list of prior authorization required services and codes

Check the list of services and code that require PA here: Parkland Prior Authorization List

No Prior Authorization required

If a request for services is submitted to Parkland Community Health's Utilization Management department which doesn't require prior authorization, the request will be returned stating prior authorization not required or Prior Authorization not required. "Prior Authorization Not Required" does not mean that service is covered.

Timelines for Initiating a Prior Authorization

Requesting providers must initiate a prior authorization of non-emergency services (e.g., elective inpatient admissions, elective/outpatient services) prior to providing the requested service. It is recommended that requests be submitted five (5) Business Days prior to the desired start date in order to allow time for processing. Submit requests by contacting PCHP's Prior Authorization department at:

www.parklandhealthplan.com

Prior Authorization Requests Turn Around Timelines

PCHP will respond to prior authorization requests within two (2) Business Days for CHIP products, and within three (3) Business Days for non-CHIP products, after receipt of the complete request for authorization of services.

Urgent requests for services to be rendered within 3 calendar Days may be submitted with a signed acknowledgement of the requesting physician using the PCHP Texas Standard Prior Authorization form and

Inpatient Notification form include requirements for a physician's signature. In order to eliminate any delays, all clinical information required must be submitted along with the authorization request signed by the requesting physician.

Authorization TAT Requirements

Program Authorization Type TAT STAR (Medicaid), Inpatient Elective 3 Business Days CHIP Outpatient, Inpatient Elective 2 Business Days CHIP and Medicaid Urgent, Outpatient and Inpatient Elective 3 calendar Days CHIP and Medicaid Inpatient 1 Business Day

Program	Authorization Type	Turn Around Time
STAR (Medicaid)	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
CHIP and (STAR)Medicaid	Urgent, Outpatient and Inpatient Elective	3 calendar Days
CHIP and (STAR)Medicaid	Inpatient	1 Business Day

Referrals

Requesting a Referral

A referral is appropriate when a Provider, determines medically necessary services, including substance abuse treatments, are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals, unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct PCHP Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed with PCHP Medicaid and CHIP. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider. Prior authorization will be required from PCHP except in the case of Emergency Services.

PCP's can refer a Member to an in-network specialist for consultation and treatment without a prior authorization request to PCHP.

If the PCP believes that a Member needs to be referred to an Out-of-Network provider, including medical partners not contracted with PCHP, documentation demonstrating the need must be submitted to PCHP for review and prior authorization before the referral can occur. There must be documentation of coordination of referrals and services provided between the Primary Care Provider and Specialist.

Members with disabilities, special health care needs, or chronic or complex conditions, have the right to designate a specialist as their PCP as long as the specialist agrees.

Referrals to Network Facilities and Contactors

Referrals to network facilities and contractors do not require a prior authorization except as specifically noted on the current Prior Authorization Guide.

Preauthorization

Overview

PCHP requires that certain services have preauthorization. The preauthorization process is used 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 clinical information provided aids in the medical review of the request.

PCHP provides prospective, concurrent, and retrospective utilization review services. The preferred method of submission is via the internet through the PCHP website at www.paraklandhealthplan.com . All services that require preauthorization must be submitted to the health plan prior to rendering services utilizing the Texas Standard Prior Authorization Request Form for Health Care Services. included in Appendix X of this manual.

Failure to obtain preauthorization may result in non-payment of claims.

Peer-To-Peer Discussion

A peer-to-peer discussion is available to the ordering physician at any time during the prior authorization, denial or appeal process. For CHIP members, the opportunity for a peer-to-peer discussion will be offered prior to issuing an Adverse Benefit Determination.

For Medicaid members, a peer-to-peer discussion will be offered at the time of an Adverse Benefit Determination. To schedule a peer-to-peer discussion of the denial, the referring physician may contact PCHP at 888-672-2277 for STAR program and 888-814-2352 for CHIP.

Members may request reconsideration of benefit determinations in accordance with the medical appeals process. Physicians are responsible for making medical treatment decisions in consultation with their patients. Any denial of preauthorization based on lack of medical necessity or documentation of such, will be made by the Medical Director.

Decision and Screening Criteria

PCHP Utilization Management does not make decisions affecting the coverage or payment of members.

Utilization Management makes decisions regarding medically necessary services based on the member's active enrollment. We do not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or care.

There are no financial incentives for Utilization Management decision-makers to encourage decisions that result in under-utilization. If you disagree with a Utilization

Management decision and would like to discuss the decision with the physician reviewer, you can call Utilization Management at 888-627-2277 (STAR) and 888-814-2352 (CHIP/CHIP Perinate)

Decision and Screening Criteria

The TX Medicaid timelines for decisions are in alignment with the Texas Department of Insurance requirements and the HHSC UMCM requirements.

Utilization Management applies InterQual Guidelines and PCHP's medical policy and clinical guidelines for Utilization Management screening and decisions. Utilization Management does not rely solely on these guidelines; we also give

Consideration to the clinical information provided as well as the individual healthcare needs of the member.

Decision criteria incorporates nationally recognized standards of care and practice from sources such as the:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons, current professional literature
- Cumulative professional expertise and experience

The decision criteria used by the clinical reviewers are evidenced-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

These criteria are available to members, physicians and other professional providers upon request by contacting Utilization Management at 888-672-2277 (STAR) or 888-814-2352 (CHIP).

Vision Services

Information about vision benefits can be obtained by calling the vision benefits vendor number listed in the "Important Contact Information" section of this Provider Manual.

Covered Persons are entitled to access Participating Provider ophthalmologists or optometrists without a PCP referral.

Case Management Program

The PCHP case management program is part of a comprehensive health care management services program offering a continuum of services that include case management, care coordination and hospital discharge case management. Members may qualify for a case management program based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. This may involve coordinating care, assisting members to access community resources, providing disease-specific education or any number of interventions designed to improve the quality of life and functionality of members. The programs are designed to make more efficient use of limited health care resources. Participation in case management is voluntary and member consent must be obtained prior to enrollment. All members have the option to opt out of case management at any time.

Members with high-risk diagnoses or conditions may trigger Case Management intervention. Examples (not inclusive) of types of members that may need Case Management intervention include:

- Members with special health care needs
- High-risk pregnancy
- Members needing a transplant
- Behavioral health
- NICU babies, post discharge
- Catastrophic cases

Upon identification of a potential member for case management, the case manager contacts the referring physician or other professional provider and member for an initial assessment. Then, with the involvement of the member, the member's representative and the referring physician or other professional provider, the case manager develops an individualized care plan.

The provider and case manager will coordinate services with public health, behavioral health, schools and other community resources as needed.

The case manager periodically re-assesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues that need to be addressed to help ensure that the member receives support and teaching to achieve care plan goals

PCHP's Case Management Program involves the Member, family or significant others, physicians, social services, community resources, and facility team members, all of whom contribute to decisions regarding care.

Disease Management Programs

Parkland Community Health Plan has contracted with, and will work in partnership with, Axis Point Health, to manage the delivery of disease management services for the Children's Health Insurance Program (CHIP) and the Medicaid State of Texas Access Reform (STAR) program. Our Disease Management (DM) services are based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. DM services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our Disease Management programs include:

- Asthma
- Diabetes

Maternity Management Program

PCHP is committed to providing its members with a proactive prenatal care program which will promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The goal of the PCHP prenatal program is to improve the birth and health outcomes of all pregnant members.

The PCHP prenatal program supports the practitioner-patient relationship and member's treatment plan and emphasizes the prevention of complications through the use of evidence based clinical guidelines and patient empowerment strategies. The PCHP prenatal program strives to improve the frequency of prenatal and postpartum care, as well as reduce the incident of low birth weight, preterm deliveries and neonatal intensive care unit (NICU) admissions. In an effort to both understand and effectively address existing disparities in health and disease patterns, the program takes into account risk factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, nutrition, and its influence on members' health throughout their lifetime, particularly during pregnancy.

To refer your patients to the PCHP Maternity Management Program, please call the Case Management department, or complete a referral form via the portal.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women is a Texas Medicaid benefit for eligible patients who have medical-related needs that might affect their health care. The patients must be eligible for Medicaid and be either:

A child, birth through age 20 with a health condition or health risk.

A woman of any age who has a high-risk pregnancy.

Texas Health Steps requires blood lead screening at the ages noted on the THSteps Periodicity Schedule. The screening must be performed as part of the medical checkup. Additionally, environmental lead risk assessments should be completed for any child at 12 months and at 24 months with no record of a previous blood lead screening test. Providers may use the Lead Risk Questionnaire, Form Pb-110, which is provided at: https://www.dshs.state.tx.us/THsteps/forms.stm or an equivalent form of their choice.

Texas law requires all blood levels, elevated and non-elevated, for members who are 14 years of age or younger be reported the Texas Childhood Lead Poisoning Prevention Program (TXCLPPP). Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Pb- 111 Point-of-Care Blood Lead Testing Report form. These forms can be found at: https://www.dshs.texas.gov/lead/Forms.aspx

Additional information, including follow up testing and care information and Centers for Disease and Control and Prevention guidelines can be found at: https://www.dshs.state.tx.us/lead/child.shtm

Practice Guidelines

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

Practice guidelines are developed nationally and adopted locally through Medical Advisory Committees that include practicing physicians who participate in the Plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the priority.

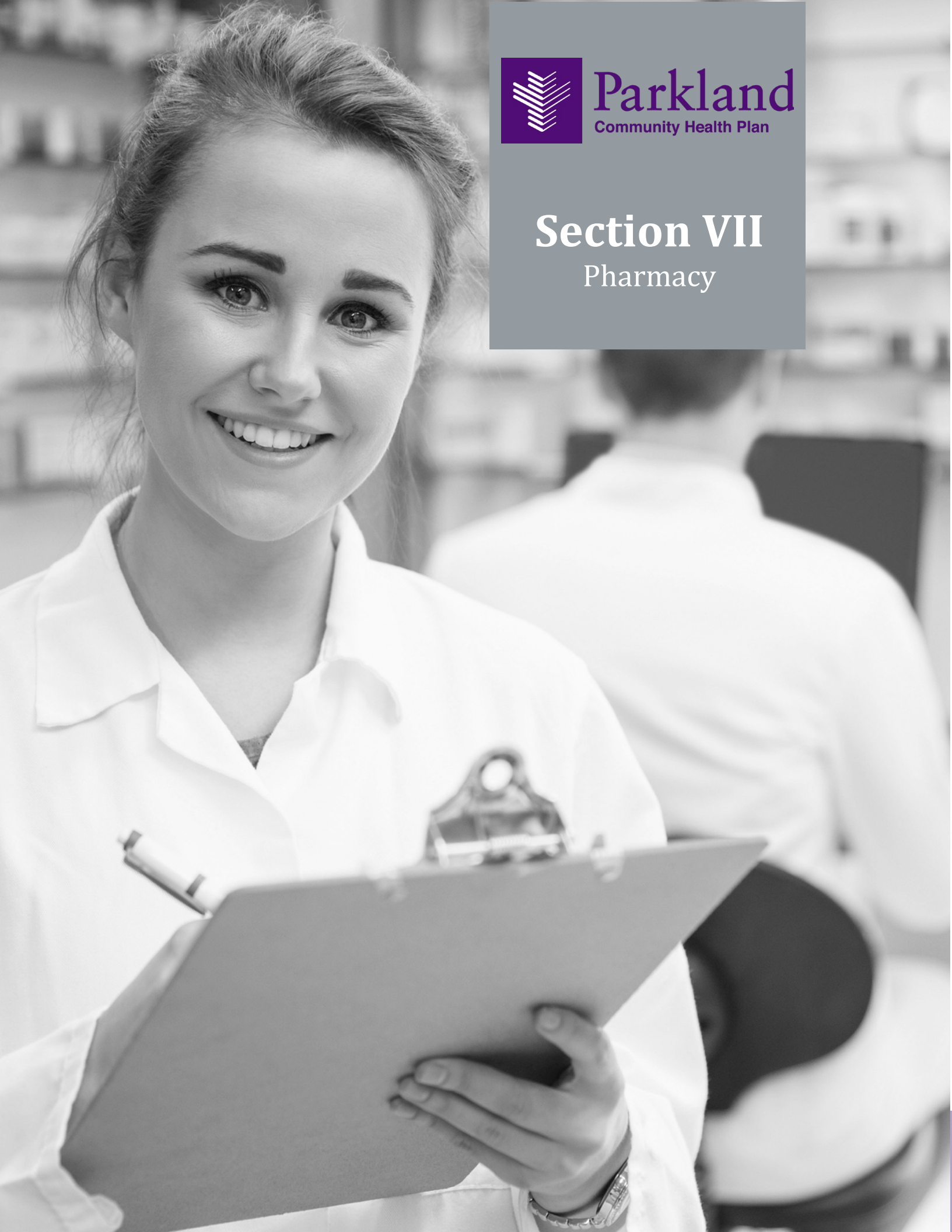
The Parkland Community Health Medicaid and CHIP programs have adopted the following guidelines:

Alcohol Use- National Institute on Alcohol Abuse and Alcoholism (NIAAA), Helping Patients Who Drink Too Much, A Clinician's Guide, 2005 Edition. This guideline can be found online at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

Addiction – American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. This guideline can be found online at: http://www.asam.org/

Asthma: National Heart Lung and Blood Institute (NHLBI) Full text and a summary report of the guidelines, along with supporting material and tools can be found at https://www.nhlbi.nih.gov/guidelines/asthma/

Attention-Deficit/Hyperactivity Disorder - American Academy of Pediatrics (AAP): Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents, October 2011. This guideline can be found online at https://pediatrics.aappublications.org/content/144/4/e20192528



Parkland
Community Health Plan

Section VII

Pharmacy

Subcontractor for Pharmacy Benefit

PCHP is contracted with Navitus Health Solutions to administer pharmacy benefits for PCHP CHIP and STAR members. Members may obtain their medications at any network pharmacy unless HHSC has placed the member in the Office of Inspector General (OIG) Lock-in program. For questions related to the formulary, the preferred drug list, billing, prescription overrides, prior authorizations, quantity limit or formulary exceptions, call Navitus at 1-877-908-6023 or access the Navitus website at www.navitus.com.

Pharmacy Provider Responsibilities

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

- Filling prescriptions in accordance with the benefit design
- Adhering to the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all medication for which they are eligible
- Coordinating benefits when a member also receives other insurance benefits

Providing a 72-hour emergency supply of prescribed medication when a prior authorization (PA) cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours.

Note: Certain drugs, such as hepatitis C drugs, are excluded from the 72-hour emergency supply rule.

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.

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.

Verification of Eligibility by Pharmacies

Texas Medicaid provides the following method to identify the program a person is enrolled in, and whether the person is eligible to receive pharmacy services through traditional Medicaid or Medicaid managed care. The National Council for Prescription Drug Programs (NCPDP) Eligibility Verification (E1) transaction. The E1 transaction is submitted through a pharmacy's point-of-sale system.

Pharmacy staff must complete the Pharmacy Eligibility Verification Portal registration form in the Eligibility Verification page of the Texas Medicaid Vendor Drug Program website.

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 PCHP 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 "03" (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 a 72-hour emergency prescription supply, pharmacies should submit the following information: Pharmacy transmits claim as they would any other prescription and will receive a message that a prior authorization is required. The pharmacy will also receive a message to dispense a 72-hour emergency prescription supply if provider is not available for a prior authorization. Call 1-844-787-5437 for more information about the 72- hour emergency prescription supply policy.

Call PCHP'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
P.O. Box 999
Appleton, WI. 54912-0999
Or fax to 920-735-5315

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

Paper Claims Submission to PCHP

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

Parkland Community Health Plan
ATTN: CLAIMS
P.O. Box 560327
Dallas, TX 75356

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

The PCHP pharmacy program utilizes the Texas Medicaid/CHIP Vendor Drug Program (VDP) formulary and Medicaid Preferred Drug List (PDL). The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories for Medicaid; it does not apply to CHIP. The list is reviewed and approved by the Drug Utilization Review Board. Please refer to the VDP formulary and PDL at www.txvendordrug.com or on the Epocrates drug information system https://online.epocrates.com/home

Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the formulary and are covered if prescribed by a licensed prescriber. OTC medications are generally not covered for CHIP members; however, an exception exists for insulin.

To prescribe medications that do not appear on the PDL or those that require clinical prior authorization, call Navitus at 1-877-908-6023 for prior authorization.

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered.

Venosets, catheters and other medical accessories are not covered and are not included when submitting claims for intravenous and irrigating solutions. Except for vitamins K and D3, prenatal vitamins, fluoride preparations and products containing iron in its various salts, we do not reimburse for vitamins or legend and nonlegend multiple-ingredient anti-anemia products. Vitamins and minerals for members under age 21 are reimbursable. We may limit coverage of drugs listed in the TDCI per the VDP.

Procedures used to limit utilization may include prior approval, cost containment caps or adherence to specific dosage limitations according to FDA-approved product labeling. Limitations placed on the specific drugs are indicated in the TDCI. The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the VDP formulary
- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the VDP formulary
- Legend contraceptives

Exception: Injectable contraceptives may be dispensed up to a 90-day supply. You may also verify covered items at www.navitus.com or by calling 1-877-908-6023.

Specialty Drug Program

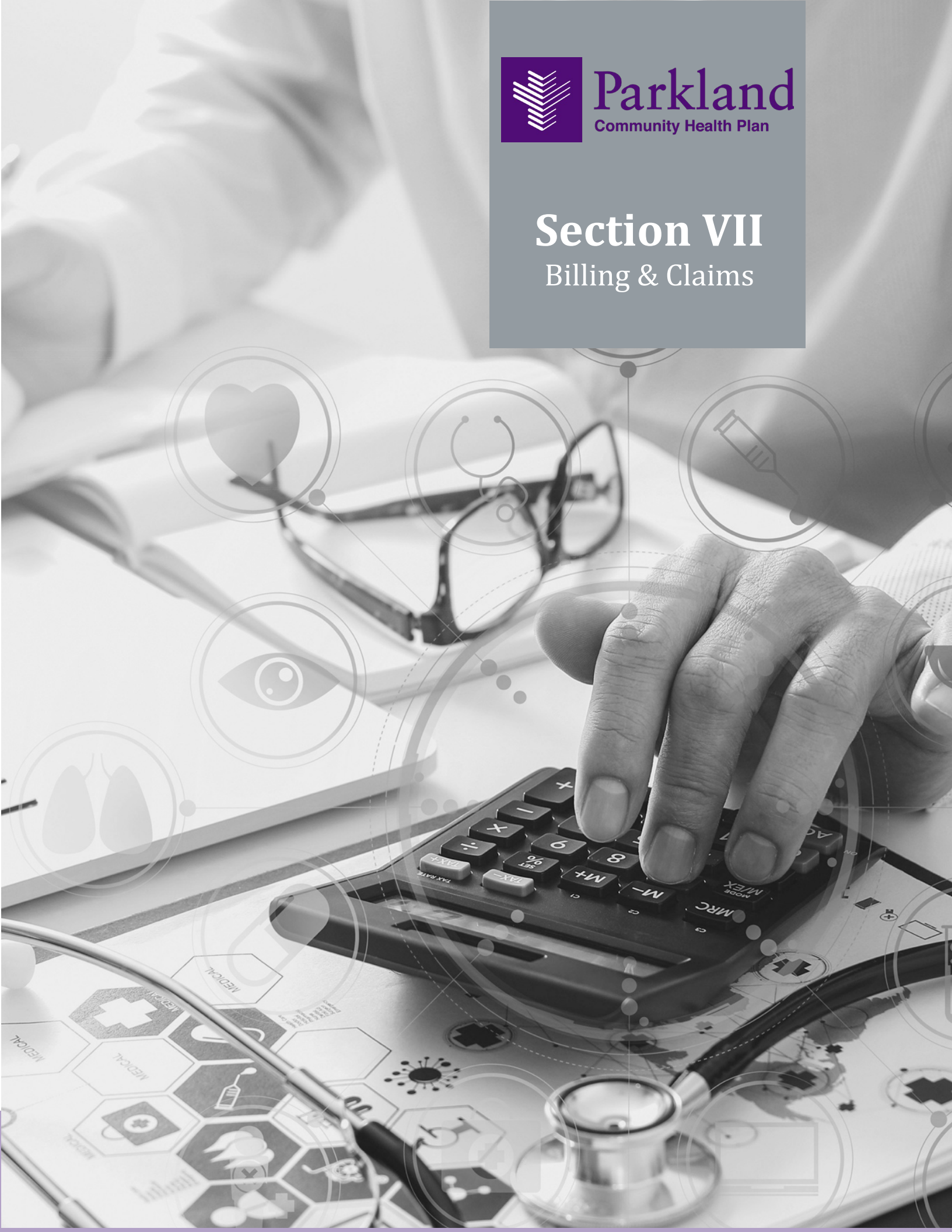
We cover most specialty drugs under the pharmacy benefit. These drugs may be obtained at any network pharmacy that handles these types of drugs. The conditions typically treated with specialty injectable drugs are: growth hormone deficiency, cancer, multiple sclerosis, hemophilia, rheumatoid arthritis, hepatitis and cystic fibrosis.

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 920-735-5312. Prescribers can also call Navitus Customer Care at 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.



Parkland
Community Health Plan

Section VII

Billing & Claims

Billing and Claims Requirement

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

Claim Forms

Generally, there are two types of forms used for submitting claims for reimbursement.

They are:

1. The CMS-1500 for professional services
2. The CMS-1450(UB-04) for institutional services

These forms are available in both electronic and hardcopy/paper format.

What is a Clean Claim?

Claims submitted correctly the first time are called 'clean'. That means that all required fields have been completed in

accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. It also means that the correct form was used for the type of service provided.

Were return claims submitted with incomplete or invalid information, and request the claim be corrected and resubmitted. If using a clearinghouse for Electronic Data Interchange (EDI), the clearinghouse/gateway also rejects claims that are incomplete or invalid. You are responsible for working with your EDI vendor to help ensure that claims that 'error out' from the EDI gateway are corrected and resubmitted.

Once a clean claim is received PCHP 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

We encourage electronic submission of claims through Electronic Data Interchange (EDI). PCHP has designated TriZetto Provider Solutions to operate and service your EDI entry point (EDI Gateway).

The Parkland Community Health Plan Payer ID for electronic claims is **Payer ID # 66917**

For more information, please email TTPSSupport@cognizant.com

To submit EDI through TPS, you will need to register as a new user if you have not done so yet. Registration Link

Methods of Electronic Submission of Claims to PCHP

TexMedConnect: Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com

Paper Claims Submission to PCHP

Paper claim forms are mailed to:

Parkland Community Health Plan

ATTN: CLAIMS
P.O. Box 560327
Dallas, TX 75356

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 an electronic corrected claim via your clearinghouse, the TMHP Claims Portal or PCHP's use the Bill and Frequency Type codes listed below:

- 7-Replacement of Prior Claim
  - 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. Hospitals and facilities should include the 7 in the third digit of the Bill Type. Physicians should submit with a Frequency Type code of 7.
- 8-Void/Cancel of Prior Claim
  - If you have submitted a claim to Parkland Community Health Plan in error, resubmit the entire claim. Hospitals and facilities should include the 8 in the third digit of the Bill Type. Providers should submit with a Frequency Type code of 8. If the claim was paid resubmit the claim to PCHP via paper and attach a check for the amount that was paid in error.

When submitting a paper corrected claim, follow these steps:

- Submit a copy of the remittance advice with the correction clearly noted.
- Ensure you use the proper frequency code in block 22

Boldly and clearly mark the claim as "Corrected Claim." Failure to mark your claim

appropriately may result in rejection as a duplicate.

Note: PCHP 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 PCHP 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 PCHP's Claims Portal, they are to call our Provider Services Department at 888-672-2277 for STAR Program Claims and 888-814-2532 for CHIP Program Claims.

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

- 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

PCHP 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 PCHP fail to pay the provider within the thirty days, interest is calculated daily for the full period in which the clean claim remains unpaid after 30 days from the date of receipt.

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 PCHP Provider Web portal at www.Parklandhealthplan.com

Providers may call our Provider Services Department at 888-672-2277 for STAR program claims and 888-814-2352 for CHIP claims which will offer our Interactive Voice Response (IVR) system to help Providers navigate or obtain information that are readily available. IVR system will be able to provide the Claim statuses, claims payment information, electronic claims payer id, paper claims submission address, etc. to Providers.

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. PCHP requests providers submit appropriate Category II Codes with all claims encounters.

Dental Claims: PCHP 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: PCHP 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: PCHP requires the use of ICD10 diagnosis codes and CPT or HCPCS procedure codes.

Inpatient Institutional Claims: PCHP 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: PCHP 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: PCHP does not process prescription drug claims. Prescription drug services are provided for STAR and CHIP Members through our subcontractor, Navitus Health Solutions. Inquiries regarding services should be directed to: 1-877-908-6023

Professional Medical Claims: PCHP 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.

PCHP Fee Schedules

PCHP 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 and http://www.tmhp.com/Pages/Topics/hospital_reimbursement.aspx

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

For additional information or reimbursement rates the provider may contact PCHP Provider Services or their Provider Business Consultant (PBC) assistance.

E&M Office Visits Billing Requirements

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

E&M Consult Billing Requirements

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

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 will be reimbursed in accordance with the hospital's or provider's agreement with PCHP. 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/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 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 transport claims must be billed with an ET modifier on each procedure code submitted on the claim. Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements.

Ambulance providers, including municipalities, should use a CMS-1500 form to bill for ambulance services. Use appropriate two-digit origin and destination codes that describe the 'to' and 'from' locations.

More information about PCHP's requirements for ambulance services can be found in the Texas Medicaid Provider Procedures Manual, available on this website www.tmhp.com.

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.

Use of Modifier 25

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

Billing for Assistant Surgeon Services

PCHP provides coverage for Assistant Surgeon services authorized in accordance with PCHP 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 PCHP Health Services for authorization.

Locum Tenens

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

We will reimburse the member's regular physician or medical group for all services (including emergency visits) of locum tenens

physician during the absence of the regular physician. This applies in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis. Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted rate.

The locum tenens physician may not provide services to a member for more than a period of 60 continuous days.

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

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

Billing for Capitated Services

Capitated providers are required to submit encounter claims for all capitation services. PCHP 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. PCHP does not reimburse for vaccines but will reimburse Primary Care Provider (PCP)'s for the administration of vaccine.

Adult Immunizations:

PCHP 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

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must Follow these general guidelines for DME billing:

- Use HCPCS codes for DME or supplies
- Use miscellaneous codes (such as E1399) when an HCPCS code does not exist for that particular item of equipment. An unlisted code like E1399 cannot be used to describe expensive or difficult-to-order items when codes for those items exist.
- Unlisted codes will not be accepted if valid HCPCS codes exist for the DME and supplies
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code (such as E1399). The invoice must be from the manufacturer, not the office making a purchase.
- Catalog pages are not acceptable as a manufacturer's invoice

Call CHIP Provider Services at 888-672-2277 or CHIP Provider Services at 888-814-2352 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

DME Billing and Reimbursement

Durable Medical Equipment (DME) providers should bill with the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the appropriate modifier will be reimbursed at rental price. Follow these general guidelines for DME billing:

Use HCPCS codes for DME or supplies

Use miscellaneous codes (such as E1399) when an HCPCS code does not exist for that particular item of equipment. An unlisted code like E1399 cannot be used to describe expensive or difficult-to-order items when codes for those items exist.

Unlisted codes will not be accepted if valid HCPCS codes exist for the DME and supplies

Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code (such as E1399). The invoice must be from the manufacturer, not the office making a purchase.

Catalog pages are not acceptable as a manufacturer's invoice.

Durable Medical Equipment Rental

Durable Medical Equipment (DME) rentals

require medical documentation from the prescribing doctor. Most DME is dispensed on a rental basis only, such as oxygen tanks or concentrators. Rented items remain the property of the DME provider until the purchase price is reached. DME providers should use normal equipment collection guidelines. PCHP is not responsible for equipment not returned by members. Charges for rentals exceeding the reasonable charge for a purchase are not accepted, and rental extensions may be obtained only on approved items

Durable Medical Equipment Purchase

Durable Medical Equipment (DME) may be reimbursed on a rent-to-purchase basis over a period of 10months, unless Specified otherwise at the time of review by our UM department.

Wheelchairs/Wheeled Mobility Aids

Medicaid guidelines are followed when calculating payments for by report(customized) wheelchair claims.

Claims documentation must include:

- Item description
- Manufacturer name
- Model number
- Catalog number
- Completion of the Reserved for Local Use field (Box 19) on the CMS-1500 claim form with the total MSRP of the wheelchair, including all wheelchair accessories, modifications, or replacement parts, and the name of the employed Rehabilitation and Assistive Technology of America (RESNA) certified technician.
- You must mark each catalog page or invoice line so it can be matched to the appropriate claim line.
- For wheeled mobility aids, in addition to the above, the invoice must be an amount published by the manufacturer before August 1,2003. If the item was not available before then, you must list the date of availability in the Reserved for Local Use field (Box19) of the CMS-1500 claim form. The catalog page that initially published the item must be attached to the claim.

Wheelchair claims from manufacturers billing as providers must include:

- The MSRP from a catalog page dated before August 1, 2003. If the item was not available before August 1, 2003, the manufacturer's invoice must accompany the claim.
- The initial date of availability must be documented in the Reserved for Local Use Field (Box 19) of the CMS-1500 claim form.

Modifiers

For a listing of DME modifier codes, please access Appendix 1 of the HCPCS 2006 publication available from the

American Medical Association (AMA), or log on to their website, www.ama-assn.orgforonlineaccess.

Billing for Texas Health Steps or Well Child Visit Services

Texas Health Steps

Newly enrolled members in STAR must be seen within 90 days of joining the plan for a Texas Health Steps visit. PCHP provides providers with a list of their assigned member with their enrollment date. Providers should reach out to these members to schedule an appointment for a Texas Health Steps checkup. A checkup for an existing member from birth through 35 months of age is

timely if received within 60 days beyond the periodic due date based on the member's birth date. A Texas Health Steps medical checkup for an existing member, age three years and older is due annually beginning on the child's birthday and is considered timely if it occurs no later than 364 calendar Days after the child's birthday.

Requirements for all Texas Health Steps claims:

Use benefit code EP1 in field 11c of the CMS1500 claim form

Use Z00121 and Z00129 field 21 of the CMS1500 claim form

No rendering NPI required for Texas Health Steps or preventive visits

No requirement to bill other insurance coverage for Texas Health Steps claims

Texas Health Steps Visits and Acute Care Services Performed on the Same Day

When a Texas Health Steps visit is billed for the same date of service as an acute care visit, both services may be reimbursed when billed by the same provider or provider group.

Providers must bill an acute care visit on a separate claim without the benefit code EP1

Providers must use modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit

CHIP Preventive Visits and Acute Care Services Performed on the Same Day

When a CHIP Preventive checkup is billed for the same date of service as an acute care visit, both services may be

reimbursed when billed by the same provider or provider group.

Providers must bill an acute care visit on a separate claim without benefit code EP1

Providers must use modifier 25 to describe circumstances in which an acute care visit was provided at the same time as a Chip Preventive visit

Use Z00121 and Z00129 for the CHIP Preventive visit

A copay will apply to the acute care services

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. PCHP 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.Parklandhealthplan.com or contacting the CHIP/STAR Members Services Department.

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. PCHP 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.

Special Billing

School Physicals	STAR & CHIP Members Only	These services do not need to be provided by the Member's Primary Care physician but must be performed by a PCHP in-network Provider. Claims for these services are billed to PCHP using diagnosis code: Z02.5
Increased Frame Allowance and Vision Services	STAR & CHIP Members Only	Claims for these services should be filed directly to Superior Vison and questions on how to file these claims should be directed to Superior at **1-800-879-6901**
NEMT	STAR Only	There is no cost to members for the NEMT benefit. Providers are not required to submit claims for these services, PCHP contracts with the transportation vendor who is responsible for billing to PCHP

Coordination of Benefits (COB) Requirements

When applicable, PCHP coordinates benefits with any other carrier or program that the member may have for coverage, including Medicare. Indicate 'Other Coverage' information on the appropriate claim form.

If there is a need to coordinate benefits, include at least one of the following items from the other carrier or program when submitting a COB claim:

- Third-party Remittance Advice (RA)
- Third-party letter explaining the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other carrier or program first. Please make sure that the information you submit explains any coding listed on the other carrier's RA or letter. We cannot process your claim without this specific information.

PCHP must receive COB claims within 95 days from the date on the other carrier's or program's RA or letter of denial of coverage.

When submitting COB claims, specify the other coverage in:

- Boxes 9a-d of the CMS-1500 claim form
- Boxes 58-62 of the CMS-1450 (UB-04) claim form

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 STAR or CHIP 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 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

To encourage responsible use of health care services, families are required to share in the CHIP program's cost by paying small copays.

Cost sharing guidelines include:

- Information about copays and annual reporting caps is based on family income; the CHIP member ID card shows the member's copay amount.
- Members must report to Texas CHIP when they or their family reach the annual reporting cap; once the cap is met, the member will be issued a new ID card.
- Upon verbal notification from the member or presentation of an ID card showing the cost-sharing limit has been met, no copay is collected from the member for the balance of the year.

Cost-sharing guidelines require that providers:

- Only bill for valid, unpaid copays and noncovered services received by the member.
- Promptly refund member overpayments if an incorrect copay was collected for covered services.
- Not collect additional payment once the copay is made.
- Verify eligibility and copay amounts by calling Provider Services at 888-672-2277 for STAR program claims and
- 888-814-2352 for CHIP claims

Cost sharing exemptions include:

- Preventive health care services such as well-child exams, immunizations and pregnancy-related services.
- Enrollment fees and copays do not apply to CHIP Perinate and CHIP Perinate newborn members.
- Copays may not be collected in excess of the cost of a covered service.

CHIP Cost Sharing Schedule CHIP Cost Sharing	
Enrollment fees (for 12-month enrollment period)	**Charge**
At or below 151 percent of FPL*	$0
Above 151 percent up to and including 186 percent of FPL	$35
Above 186 percent up to and including 201 percent of FPL	$50
Copays (per visit):	
At or below 151 percent of FPL	**Charge**
Office visit (non-preventative)	**$5**
Nonemergency ER	**$5**
Generic drug	**$0**
Brand drug	**$5**
Facility copay, inpatient (per admission)	**$35**
Cost-sharing cap	**5 percent (of family's income)****
Above 151 percent up to and including 186 percent of FPL	**Charge**
Office visit (non-preventative)	**$20**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug	**$35**
Facility copay, inpatient (per admission)	**$75**
Cost-sharing cap	**5 percent (of family's income)****
Above 186 percent up to and including 201 percent of FPL	**Charge**
Office visit (non-preventative)	**$25**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug	**$35**
Facility copay, inpatient (per admission)	**$125**
Cost-sharing cap	**5 percent (of family's income)****

* The Federal Poverty Level (FPL) refers to income guidelines established annually by the federal government.

** Per 12-month term of coverage

Billing Members for Non-Covered Services

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment from Members for Medicaid covered services. Providers may not bill or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to Section 1.4.9 of the Texas Medicaid Provider Procedures Manual found at TMPPM Link

Private Pay Agreement/Member Acknowledgement

If a Parkland Community Health Plan Member decides to go to a provider that is not within the Parkland Community Health plan's network or chooses to get services that have not been authorized or are not a covered benefit, the Member must document his/her choice by signing the Private Pay Agreement and the Member Acknowledgement form.

If a claim is not received by Parkland Community Health within 95 days, the claim will be denied unless exempted from the claims filing deadline. For more information, refer to the Texas Medicaid Provider Procedures Manual, Section 6.1.3, "Claims Filing Deadlines," which includes exceptions for inpatient facility claims, claims by newly-enrolled Medicaid providers, claims by out-of-state providers, and other exceptions TMPPM Link

Participating providers shall be paid by us, no later than 30 working days after receipt of a completed "clean" claim for covered services. A clean claim is one that is accurate, complete (that is, includes all information necessary to determine Parkland Community Health liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). Parkland Community Health will indicate to participating providers within 30 days of receipt if claims received by Parkland Community Health, are not clean claims.

Providers Required to Report Overpayment

When a claims overpayment is discovered, PCHP will notify the provider. If a provider is notified by PCHP of an overpayment, or discovers that they have received an overpayment, the provider should return the overpayment to PCHP by mailing a check and a copy of the overpayment notification to:

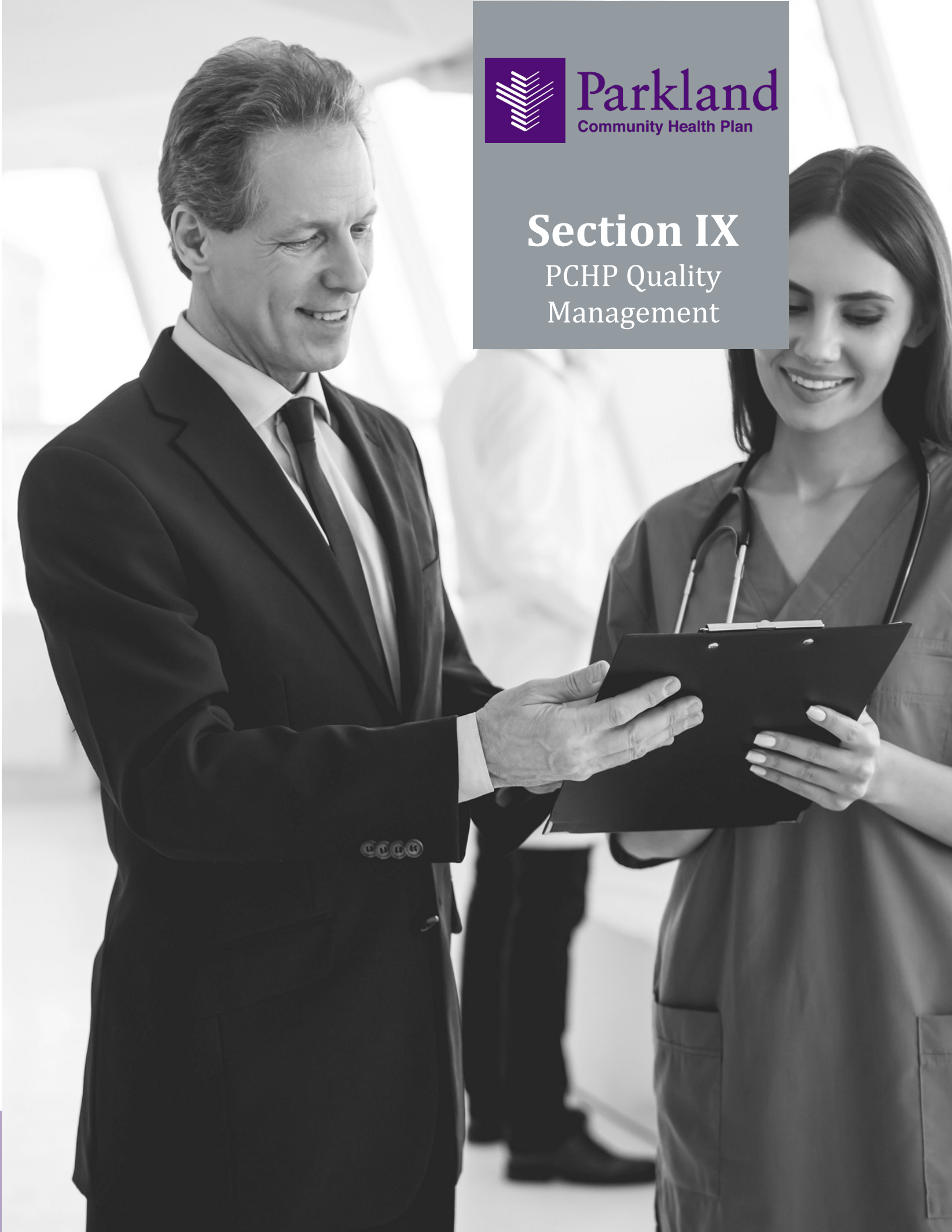
Parkland Community Health Plan

ATTN: REFUNDS
P.O. Box 560307
Dallas, TX 75356

Provider Claim Appeals

All claim appeals must be filed within **120 days** of date of the Explanation of Payment (EOP). To submit an appeal regarding claim payment, please submit a copy of the **Explanation of Payment (EOP) with the claim in question, and a written explanation of your appeal to:**

Parkland Community Health Plan
Attn: Appeals and Complaints
P. O. Box 560347
Dallas TX 75356
Fax: 1-844-310-1823



Parkland
Community Health Plan

Section IX

PCHP Quality Management

PCHP Quality Management Program

What is quality?

Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results. Although we would like to think that every health plan, doctor, hospital, and other provider gives high quality care, this is not always so. Quality varies for many reasons.

The Quality Improvement Program is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. Parkland Community Health complies with all State and federal requirements regarding Quality Improvement (QI). The QAPI Program is overseen by the governing board and committees whose membership broadly represents the network of participating providers and Members.

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

PCHP Quality Assurance Committee

The Quality Assurance Committee provides a forum for interdepartmental members of the committee to engage in review, coordination and direction of the Medicaid Quality Management programs. It oversees the credentialing and peer review committee, which provides a systematic approach for monitoring the quality and appropriateness of care.

Additionally, the program provides approval recommendations for activities relating to key processes, clinical guidelines, and Medicaid-specific policies and procedures. The program's responsibilities are to:

- Implementation, oversight and revision of PCHP's QAPI Plan and its component parts and any related issues.
- Timely receipt and review of reports from the PCHP Administrator(s), Delegated Entities, and PCHP employees related to the QAPI Plan and related policies and programs, as required by the State Agencies or Board directive, and for requesting any necessary/prudent follow up by PCHP on same.
- Preparation and submission of all required reports or information to the State Agencies.
- Receipt of information and recommendations from the Provider Quality of Care Committee and its Sub-Committees, and the Provider Advisory Group, and ensuring any necessary/prudent follow up on it.
- Making any necessary coverage determinations based on the Provider Quality of Care Committee's and the Medical Technical Assessment Sub-Committee's assessment of medical technologies and processes, and as required by the State Programs.
- Ultimate oversight of the Delegated Entities and Plan Administrator(s).
- Creation and oversight of programs sufficient to analyze and resolve other quality-related issues as may arise from time to time.

PCHP Provider Quality Measures

- HEDIS measures
- PPV - Potentially Preventable Emergency Room Visits
- CAHPS Clinician & Group Survey - (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices
- CMS Core Set Adult Measures
- CMS Core Set Child Measures

PCHP HEDIS® Measurements

HEDIS measures - The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry. Implemented in the early 1990s to measure health plan performance, HEDIS incorporated physician-level measures in 2006. HEDIS is managed by the National Committee for Quality Assurance (NCQA), a private, non-profit organization that accredits and certifies healthcare organizations.

HEDIS measures of physician quality address:

- The effectiveness of care.
- Access to care.
- The use of services.

Most of the measures of physician quality are adapted from HEDIS indicators commonly reported at the health plan level. They can be used to assess performance at the individual, practice site, or medical group level. Many of the measures have NQF's endorsement.

How to Get Involved in the PCHP Quality Program

If you want to get involved in the PCHP Quality Program, please reach out to our Director of Quality Improvement Jeniffer Gonzalez at Jeniffer.Gonzalez@phhs.org

Provider Report Cards

[Under development]

Confidentiality

Participating Providers must treat all information obtained through the performance of the Covered Services as confidential information to the extent required by law, including but not limited to HIPAA. This includes, but is not limited to, information relating to applicants or recipients of State Programs.

Participating Providers may not use information obtained through the performance Covered Services in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Participating Provider's Agreement with PCHP.

Before disclosing confidential information, Participating Providers must give Covered Persons a Notice of Privacy Practices and obtain their Authorization for Release. These documents may be found at Appendix P.

Focused Studies and Utilization Management Reporting Requirements

PCHP, along with Beacon, has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to PCHP members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member's overall care. PCHP and Beacon will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

Practice Guidelines

Practice guidelines are developed nationally and adopted locally through Medical Advisory Committees that include practicing physicians who participate in the Plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the first priority.

The Parkland Community Health Medicaid and CHIP programs have adopted the following guidelines:

- Alcohol Use- National Institute on Alcohol Abuse and Alcoholism (NIAAA), Helping Patients Who Drink Too Much, A Clinician's Guide, 2005 Edition. This guideline can be found online at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- Addiction – American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. This guideline can be found online at: http://www.asam.org/
- Asthma: National Heart Lung and Blood Institute (NHLBI) Full text and a summary report of the guidelines, along with supporting material and tools can be found at https://www.nhlbi.nih.gov/guidelines/asthma/
- Attention-Deficit/Hyperactivity Disorder - American Academy of Pediatrics (AAP): Diagnosis,

Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents, October 2011. This guideline can be found online at https://pediatrics.aappublications.org/content/144/4/e20192528

Parkland
Community Health Plan

Section X

Credentialing & Recredentialing

Initial Credentialing Information

The PCHP credentialing process is consistent with NCQA guidelines and the State of Texas requirements to practice. PCHP requires full credentialing of the following office-based physicians and other professional providers for participation in the Medicaid (STAR) and CHIP networks.

- Advanced Practice Nurse (APN)
- Audiologist (AUD)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Medical Doctors (MD)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DMD)
- Doctor of Osteopathy (DO)
- Doctor of Podiatric Medicine (DPM)
- Occupational Therapist (OT)
- Licensed Physical Therapist (LPT)
- Physician Assistant (PA)
- Registered Dietician (RD)
- Speech and Language Pathologist (SLP)

Behavioral health professionals and physicians must contact Beacon at 888-204-5581 or www.beaconhealthoptions.com/providers/beacon/network/ for questions regarding the credentialing or re-credentialing process for the Medicaid (STAR) and CHIP networks.

PCHP Provider Credentialing and Recredentialing Information

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

Providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with PCHP as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.

PCHP will utilize the Credentialing Verification Organization (CVO), Aperture, for all initial credentialing and recredentialing requests. Aperture will collect all credentialing applications, forms, licenses and other relevant information needed to validate a provider's credentials — this is called primary source verification (PSV).

Upon review of the PSV, Aperture will notify PCHP whether a file is complete or incomplete. You will receive a final notification from PCHP upon completion of all credentialing-related actions.

As an applicant for participation in our network, each provider has the right to a fair review of their submitted credentials including license information, malpractice case review, complaints and appeals, claims information, and any other relevant information that will support a comprehensive decision to serve in the PCHP network. Upon notification of a discrepancy, the provider has the right to explain information obtained from another party that may vary substantially from the

information provided in the application and to submit corrections to the facts in dispute. The provider must submit a written explanation or appear before the credentialing committee if deemed necessary.

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

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

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

- Be a member of a provider group already contracted with PCHP
- Be Medicaid-enrolled
- Agree to comply with the terms of the existing provider group contract
- Timely submit all documentation and other information required to begin the credentialing process

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

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement.

Submit changes to:

Provider Relations
Parkland Community Health Plan
1341 W. Mockingbird Ln, Suite 400E
Dallas, TX 75247

Credentialing Decision Appeal Process

If an adverse initial credentialing or recredentialing decision is made, PCHP will notify the provider of unsuccessful credentialing within 10 Business Days of the decision made. The notification shall include the reason for the adverse decision, a request for additional information (if applicable), and the right of the provider to appeal the decision with the instructions on how to appeal the decision made within thirty (30) Business Days.


TEXAS STAR
Your Health Plan ★ Your Choice

Texas STAR Program

SECTION A

STAR Eligibility of Members

HHSC Determines Eligibility

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

For other help, call PCHP Member Services at:

Parkland HEALTH*first* 1-888-672-2277

Parkland KIDS*first* 1-888-814-2352

Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP and STAR. 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

STAR Members receive a Medicaid card from the State. To confirm member eligibility, providers may contact PCHP.

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 PCHP 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.

PCHP also issues a Member ID card. An example of this card is included in Appendix . 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 PCHP 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 PCHP 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 PCHP enrollment for the date of service prior to services being rendered. There are several ways to do this:

Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.

Use TexMedConnect on the TMHP website at **www.tmhp.com**.

Call the Your Texas Benefits provider helpline at **1-855-827-3747.**

Call Provider Services at the patient's medical or dental plan or utilize the health plan's online provider portal.

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

IMPORTANT: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at **www.YourTexasBenefitsCard.com.** A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid Health Information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To learn more about the portal, visit www.YourTexasBenefits.com and download the 'Welcome Pack'. The specific functions available through the portal are:

Ability to view health information such as:

- Vaccinations
- Prescription drugs
- Past Medicaid visits
- Health Events, including diagnosis and treatments
- Lab Result
- Verification of Medicaid patient eligibility and ability to view patient program information.
- Ability to view Texas Health Steps Alerts.
- Ability to check-in and check-out patients at time of appointment.
- Ability to view and print the patient's Medicaid card.
- Ability to authorize provider-level functionality to a delegate.
- Ability to use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log into the online portal www.YourTexasBenefits.com where they can see their benefit and case information, view, print, or order a Medicaid card, set up and view Texas Health Steps Alerts, choose whether or not to share health information, and adult patients can now view their available health information online.

If you have questions, call 1-855-827-3747 or email ytb-card-support@hpe.com.

Newborn Eligibility

Encourage your patients to call a Texas Department of State Health Services (DSHS) social worker to let them know about the pregnancy.

For hospitals: At the time of delivery, please complete the HHSC form 7484, Hospital Report (Newborn Child or Children), and mail to the address identified on the form within five days of the birth. Prompt submission of this form to HHSC will expedite the process of assigning the newborn the Medicaid identification number needed for submission of Claims to the assigned plan.

For members: After the baby is born, the member will receive a Medicaid ID Form 3087 that says Newborn Call Plan. The baby is part of the mother's health plan for 90 days following the date of birth if the mother applies for Medicaid. The state will retroactively, to the date of birth, enroll newborns in PCHP designated by the mother.

Once enrolled, if the member hasn't called PCHP to choose a primary care provider (PCP) or other professional provider for their baby, they can call 1-888-672-2277; TTY 711 to choose one. If the parent does not choose, one will be chosen for the newborn member.

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.

Disenrollment from Health Plan

If a member requests disenrollment from the managed care program, PCHP will provide the member with information on the disenrollment process and direct the member to Maximus, the HHSC Administrative Services Contractor. If the request for disenrollment includes a member complaint, the complaint will be processed separately from the disenrollment request through the complaint process.

Members' disenrollment requests from managed care will require medical documentation from the PCP or documentation That indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make the final determination.

SECTION B
STAR Medicaid Covered Services

STAR Managed Care Covered Services

The following chart details the Member benefit package available to Parkland Community Health Plan Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at www.tmhp.com at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx for the listing of limitations and exclusions.

Covered Benefit	Authorization/Notification	Comments
Adult Well-Check	• No authorization is required	Annual physical for adults age 21 and over once per calendar year.
Ambulance Services	• No authorization required for emergent transport • Authorization required for non-emergent transport	Medicaid reimbursement is limited to basic life support ambulance services and air ambulance services (fixed wing and helicopter) and for instances of emergency and in non-emergency situations for the severely disabled only where use of an ambulance is the only appropriate means of transportation. Prior Authorization is needed for Air Transport and Non-emergent Ambulance Services
Ambulatory Surgical Center (ASC) Services		Covered services are minor surgical services that normally do not require hospital admission or inpatient stay. Only the procedures specified on the Centers for Medicare and Medicaid Services (CMS) approved list and selected Medicaid-only procedures are covered services provided in an ASC. Covered services are based on CMS Ambulatory Surgical Code groupings 1 through 9 and HHSC group 10.

Behavioral Health Services (Inpatient)	Authorization is required for: • In patient admission Intensive outpatient treatment (*CDTF/SUD only) • Partial hospitalization • Residential treatment Psychological testing	○ Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. ○ Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid Program and are subject to UR requirements. Includes inpatient psychiatric services, up to annual limit, - ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation. Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.
Behavioral Health Services (Outpatient)	Authorization is required for: • In patient admission Intensive outpatient treatment (*CDTF/SUD only) • Partial hospitalization • Residential treatment • Psychological testing No authorization is required	○ Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders. Includes outpatient psychiatric services, up to annual limit, ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation. ○ Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT).

		○ Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or other outpatient setting. ○ Does not require a primary care provider referral. ○ Psychological and Neuropsychological testing are covered for specific diagnoses. ○ Psychological testing ○ Neuropsychological test battery ○ Additional services such as mental health screenings are covered under the Texas Health Steps-CCP program. Medicaid clients age 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist.
Birthing Center		A Birthing Center is: A facility that is not administrative, organizational, or financial part of a hospital. Organized and operated to provide maternity services to outpatients. Complies with all applicable federal, state, and local laws and regulations. 24 Birthing Center services include: Admission Labor – ante-partum care Delivery Postpartum care Total obstetrical care

Certified Nurse Midwife (CNM) Services		Covered services include those services that are normally outside of the maternity cycle to the extent that the midwives are authorized to perform under state law. CNMs may be reimbursed for primary care services provided to women throughout the life span and newborns for the first two (2) months of life, in addition to the maternity cycle (antepartum, intrapartum, and postpartum).
Chiropractic Services		The following chiropractic services are available only to Medicaid members under 21 years of age: Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment.
Dialysis	Authorization required	
Durable Medical Equipment	All providers must obtain prior authorization for the member's use of medical equipment and supplies over $1000.	The member's Primary Care Provider/Specialist must complete the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed before requesting prior authorization for DME equipment and supplies. All signatures must be current, unaltered, original and handwritten. Computerized or stamped signatures will not be accepted. The Title XIX form must include the procedure code and quantities for services requested. The Title XIX must be maintained by the DME provider and the prescribing physicians in the client's medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician.

Emergency Services		• Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished within the United States by a provider qualified to furnish emergency services. Emergency services includes health care 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 or not an emergency exists.
Family Planning Services		Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Covered services must include, but are not limited to: Family planning annual visit Comprehensive health history and physical examination Follow-up office visit Member education and counseling to include preconception counseling Laboratory tests, prescriptions and contraceptive devices Pregnancy testing Sterilization services (federal sterilization consent form required) Federal law requires under §1915(b) waivers that members be allowed to retain the right to choose any Medicaid participating family planning provider.

Genetic Services		Genetic services are services to evaluate members regarding the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders. These services must be prescribed and performed by or under the supervision of a clinical geneticist (M.D. or D.O.). Covered services include genetic history and physical examination; genetic laboratory services and echography; genetic radiological services; genetic diagnostic procedures; and genetic counseling.
Hearing Aid Services	Cochlear implants and augmentative devices require authorization	• Persons under 21 years of age should be referred to the Department of State Health Services (DSHS) Program for Amplification for Children of Texas (PACT). • Hearing aid evaluation with combined audiometric assessment is available for Medicaid members over 21 years of age.
Home Health Services		The member must exhibit a condition where leaving their home is medically inadvisable. Benefits include fifty (50) home visits per year, selected medical supplies, durable medical equipment, and necessary repairs of this equipment. Visits beyond the 50-visit limit and additional services are allowed, if determined to be medically necessary and authorized prior to delivery.

Hospital – (Inpatient Services)	• Authorization required for all inpatient hospitalizations, including Observation (48 hour) stays	Inpatient hospital services include medically necessary items and services ordinarily furnished by a hospital under the direction of a physician for the care and treatment of inpatient members. Inpatient hospital services include the following items and services: o Bed and board in semi-private accommodations, intensive care or coronary care unit; includes meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semi- private accommodations. Bed and board in private accommodations is covered if required for medical reasons, as certified by a physician. o Whole blood and packed red blood cells reasonable and necessary for treatment of illness or injury, unless they are otherwise available without cost. o Maternity care includes usual and customary care for all pregnant members and specialized prenatal care for women with specific problems. o Newborn care includes routine care and specialized nursery care for newborns with specific problems.

Hospital – (All Outpatient Services)	• Authorization required for outpatient surgery No authorization required for outpatient services	All medically necessary ancillary services and supplies ordered by a provider. Hospital outpatient services include those services performed in the emergency room or clinic setting of a hospital. o This includes services provided to members in a hospital setting who are not confined for inpatient care. o Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a hospital. o This does not include drugs or biologicals taken home by the member. o Supplies provided by a hospital supply room for use in physician's offices in the treatment of patients are not reimbursable as outpatient services.
Inpatient Medical with Substance Abuse Treatment Services		Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.

Lab and X-Ray Services	No authorization for in-network provider labs	Medicaid benefits are provided for professional and technical services ordered by a qualified practitioner and provided under the personal supervision of a qualified practitioner in a setting other than a hospital (inpatient or outpatient). Medicaid does not reimburse baseline or screening laboratory studies. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with
Maternity Clinic Services (MCS)		A maternity service clinic is: A facility that is not an administrative, organizational, or financial part of a hospital. Organized and operated to provide maternity services to outpatients. Complies with all applicable federal, state, and local laws and regulations. Maternity clinic services are those medical services provided by registered nurses and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during her prenatal period and subsequent 60-day postpartum period. MCS benefits do not include deliveries. Covered clinic services include, but are not necessarily limited to, risk assessment, medical services, specific laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and patient education regarding maternal and child health.

Medical Checkups	No authorization required	Checkups for Members under the age of 21 are covered under the Texas Health Steps Program
NEMT		• Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus. • Commercial airline transportation services. • Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary. • Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor. • Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain 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.
OB/GYN Services		Females may seek Obstetrics and Gynecological Services from any participating network obstetrician/gynecologist (OB/Gyn) provider without a referral from their primary care provider. These care providers must perform services within the scope of their professional specialty practice. A properly credentialed OB/Gyn

		must practice in accordance with Section 4, Article 21.53D of the Texas Insurance Code and follow rules promulgated by the Texas Department of Insurance (TDI).
Outpatient Substance Abuse Treatment Services		Counseling for children and adolescents must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards and determined by a qualified credentialed counselor to be reasonable and necessary for a person who is chemically dependent. Counseling is available for children and adolescents age 13-17 years. Younger children (age 10-12 years) and young adults (age 18-20 years) may receive counseling when assessment criteria is met. Group counseling is limited to 135 hours per client, per calendar year. Individual counseling is limited to 26 hours per client per calendar year. Inpatients residing in a DSHS facility are not eligible for outpatient services. Does not require a Primary Care Provider referral.

Occupational Therapy		Occupational therapy services are a covered benefit if performed in an inpatient or outpatient hospital setting and if it meets the following criteria: It is prescribed by the member's physician and performed by a qualified occupational therapist. The therapy is prescribed for an acute condition with a diagnosis involving the muscular, skeletal, and neurological body systems. It is designed to improve or restore an individual's ability to perform those tasks required for independent functioning. The physician expects the therapy to result in a significant practical improvement in the individual's level of functioning within 30 days. For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.
Optometry and Vision		Members under age 21 are limited to one examination with refractions for the purpose of obtaining eyewear once every state fiscal year (September 1 through August 31). For members under the age of 21, this can be exceeded where a school nurse or teacher requests the eye exam, or when determined to be medically necessary. Members age 21 and over are allowed one eye exam for refractive error once every 24 months. Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above. Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction which cannot be accomplished by glasses. Vision services provided through Superior Vision.

		Additional eye health care provided by an in-network optometrist or ophthalmologist (other than surgery) can be provided without a referral from the member's Primary Care Provider. Covered surgical/laser care requires prior authorization.
Oral Evaluation and Fluoride Varnish	No authorization required	For ages six (6) through thirty- five (35) months as part of the Texas Health Steps visit
Pharmacy		All members are entitled to a pharmacy benefit as described later in this manual.
Physical Therapy		Covered benefits include services to members suffering from an acute musculoskeletal and/or neuromusculoskeletal condition. Services provided as a result of an exacerbation of a chronic condition necessitating therapy to restore function may also be covered. The Physical Therapist must have the following on file for each member treated: A treatment plan established by the member's physician and/or Physical Therapist that identifies diagnosis, modalities, frequency of treatment, expected duration of treatment, and anticipated outcomes. A written prescription by the member's physician for the therapy services.
Podiatry Services	No authorization required	Podiatrists eligible to be enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their license as DPM and when such procedures would also be reimbursable to a physician (M.D. or D.O.) under Texas Medicaid. Podiatry services are only eligible for members under the age of 21. Some of these services may be provided by the Primary Care Provider.

Prenatal Care	No authorization required	Please submit PCHP Pregnancy Notification Form
Speech and Language Therapy		Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. Speech-language pathology therapy is allowed only for acute or sub-acute pathological or traumatic conditions of the head or neck that would affect speech production. To be covered, benefits must be: Prescribed by a physician and provided as an inpatient or outpatient hospital service. Prescribed by a physician and performed by or under his personal supervision. The therapy may be performed by either a speech-language pathologist or audiologist if they are either on staff at the hospital or under the personal supervision of the physician. For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate.

Private Duty Nursing		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.
Primary Care Services	No authorization required	
Radiology, Imaging, and X- rays	Authorization required for PET Scan Authorization required for >3 OB ultrasounds Authorization required for POS 12 (Mobile in Home)	No other authorization required if performed at in-network facility and in-network provider
Renal Dialysis		Renal dialysis services are available for members with one of the following diagnosis: • Acute renal disease – a renal disease with a relatively short course, the cause of which is usually correctable. • Chronic renal disease (end-stage renal disease) – a stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health. Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

Respiratory Care		Covered respiratory services include: oxygen, nebulizers, breathing treatments, medication for breathing treatments, and inhalers.
Screening, Brief Intervention and Referral to Treatment Benefit (SBIRT)		Parkland Community Health Plan provides for SBIRT, a comprehensive approach to the delivery of early intervention and treatment services for Members with substance use disorders and those at risk of developing such disorders. Substance use screenings performed in hospital emergency departments can be covered and reimbursed and are encouraged as a means of early identification and resolution of substance use problems. To learn more about the screening, brief intervention and referral to treatment benefit (SBIRT) and how it can be provided and billed, please refer to the following TMHP links Screening Brief intervention and Referral to Treatment Benefit for Texas Medicaid http://www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf
Specialty Physician Services	Authorization required,	

Texas Health Steps Medical Checkups		Texas Health Steps is federally mandated and provides basic primary care medical screening services for all Medicaid members under 21 years of age. Medical checkups are covered for persons under 21 when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the member's age, when screening services are covered.
Texas Health Steps - Comprehensive Care Program (CCP)		A federally mandated program that provides for any health care service that is medically necessary and appropriate for all members under 21 years of age, regardless of the limitations of Texas Medicaid.
Therapies – Physical, Speech, Occupational	Authorization required including initial evaluation	Verification that a child can hear prior to the initiation of speech therapy is required. Usually hearing verification is available as part of the Texas Health Steps exam from the Primary Care Provider (PCP) though exams can be performed by any credentialed audiology department at a hospital or ENT office.
Total Parenteral Nutrition (TPN)/Hyper-alimentation		TPN is a covered benefit for eligible members who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services include but are not necessarily limited to: • Parenteral hyperalimentation solutions and additives as ordered by member's physician. • Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives.

		• Education of the member and/or appropriate family members or support persons regarding the administration of TPN before administration initially begins. (Education must include the use and maintenance of required supplies and equipment.) • Visits by a Registered Nurse appropriately trained in the administration of TPN. • Customary and routine laboratory work required to monitor the member's status. Enteral supplies and equipment, if medically necessary in conjunction with TPN.
Transplant Services	Authorization required	• Transplant services include liver, heart, lung, heart/lung, bone marrow, cornea, peripheral stem cell, and kidney transplants. Coverage of organ transplants is limited to those services that are determined reasonable, medically necessary, and standard medical procedures. Coverage does not include donor expenses or services. Coverage of each type of solid organ transplant is limited to a lifetime benefit of one initial transplant and one subsequent re-transplant due to rejection. Coverage for solid organ transplant includes procurement of the organ and services associated with the procurement. Benefits are not available for any experimental or investigational services, supplies, or procedures.

General Listing of Covered Services and Exclusions

All Covered Services must be Medically Necessary as defined by the State Programs (consult the TMPPM for the current definition). A link to a list of Covered Services and exclusions from and limitations to coverage is found at Appendix F (CHIP/CHIP Perinate) and Appendix J (Medicaid).

"Spell of illness" limitation removed

Members of the Parkland Community Health Medicaid program members are not limited by the "spell of illness" limitation, which is specified in the current Texas Medicaid Provider Procedures Manual. The annual limit of $200,000 on inpatient services does not apply for Medicaid Members.

Annual Dollar Limit for Inpatient Services

The $200,000 annual limit for inpatient services does not apply to STAR members.

Medically Necessary Prescription Drugs for Adults

STAR Members who are 21 years of age or older may receive unlimited medically necessary prescription drugs.

PCHP Value Added Services * certain restrictions may apply

Value Added Services Effective 09/01/2020	STAR	CHIP	CHIP PERINATE
24 hour Nurse Line – You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about you or your child's health needs. For STAR, call: 214-266-8773 or Toll Free 1-888-667-7890 For CHIP, call: 214-266-8766 or Toll Free 1-800-357-3162	X	X	X
Pregnancy classes at no charge to members at certain places for pregnant members and their partners.	X	X	X
Medicaid Members enrolled in the Federal Lifeline Program receive a free cell phone to include data, minutes and text messaging for members. Parkland Community Health Plan Medicaid members will receive unlimited calls to Parkland Community Health Plan Member Services Free health education messages from Text4Babies, Text4Kids, Text4Health, Care4Life, and Text2Quit.	X		
Adult Dental Services: Up to $300, per year for dental checkups, x-rays and cleaning for members 21 and older	X		
Vision Services: $150 yearly allowance, towards upgrades on frames for members	X	X	
Sports Physical: 1 sports physical each school year for members ages 3 to 19	X	X	
Sign up for Parkland Community Health Plan's Be In Control Program for educational materials for asthma and diabetes	X	X	
Gym membership for 6 months to current members ages 13-20 with a diagnosis of obesity, yearly	X	X	
200 points ($20 value) for first time member enrollment into the online Member Portal at www.parklandhealthplan.com	X	X	
200 points ($20 value) annually for members who complete a behavioral health follow up within 30 days after hospitalization for a behavioral health diagnosis	X	X	
200 points ($20 value) for the completion of each timely Texas Health Steps checkups for ages 2 months; 4 months; and 6 months	X	X	
250 points ($25 value) for the completion of each timely well child checkups for ages 9 months; 12 months; and 15 months	X	X	

250 points ($25 value) to members ages 12 to 18 who complete a timely Texas Health Steps checkup	X	X	
250 points ($25 value) annually for members who receive annual flu shot	X	X	X
250 points ($25 value) annually to new members who complete a PCP visit within 90 days of joining the health plan	X	X	
250 points ($25 value) annually for members age 10+ who complete the 3-week Step-Up Challenge	X	X	
250 points ($25 value) annually for members receiving initial medications for ADHD and who received a follow-up visit within 30 days of joining Parkland Community Health Plan	X	X	
250 points ($25 value) annually for completion of chlamydia screening	X	X	
300 points ($30 value) annually for members who complete a behavioral health follow up within 7 days after hospitalization for a behavioral health diagnosis	X	X	
300 points ($30 value) annually for being enrolled in the Be In Control Program for 3 months	X	X	
400 points ($40 value) annually for completion of prenatal checkup within the 1st trimester or within 42 days of joining Parkland Community Health Plan	X	X	X
500 points ($50 value) annually for being enrolled in the Be In Control Program for 6 months	X	X	
Up to 600 points ($60 value) annually for asthma medication refills	X	X	
600 points ($60 value) per pregnancy for members who receive their postpartum checkup within 21-56 days of delivery, while enrolled in Parkland Community Health Plan	X		
250 points ($25 value) annually for STAR members who follow-up with their primary care provider within 7 days of a hospital discharge	X		

****Limitations and restrictions apply for each Value Added Service.****
Members must be enrolled with Parkland Community Health Plan at the time of the checkups, exams and/or test.

Family Planning Services

Participating Providers must provide counseling and education about contraceptive and/or family planning services if the Covered Person request this information. Parental consent may not be required. Participating Providers must comply with the laws governing Covered Persons' (including minors') confidentiality when providing information on family planning and/or contraceptive services.

NONEMERGENCY MEDICAL TRANSPORTATION SERVICES (NEMT) NONMEDICAL TRANSPORTATION (NMT)

What are NEMT services?

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 an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

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.
- 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 healthcare service. The ITP can be the member, the member's family member, friend, or neighbor.
- Members aged 20 or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members aged 20 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 aged 20 or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a member needing assistance while traveling to and from his or her appointment with you, 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 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent of a parent or guardian, or other authorized

adult on file to travel alone. Parental consent is not required if the covered healthcare service is confidential in nature.

If you have a member you think would benefit from receiving NEMT services, please refer him or her to PCHP at 1-888-667-7890 (HEALTH*first*) or 1-800-357-3162 (KIDS*first*) for more information.

Dental Managed Care Covered Services

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.

Role of Main Dental Home

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

Primary and Preventative Dental Services

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.

Emergency Dental Services

Medicaid Emergency Dental Services:

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

Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and

Treatment of oral abscess of tooth or gum origin.

CHIP Emergency Dental Services:

Parkland Community Health 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.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:

Parkland Community Health is not responsible for paying for routine dental services provided to Medicaid Members.

These services are paid through Dental Managed Care Organizations.

Parkland Community Health 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 aged 6 through 35 months.

Billing guidelines

In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier.

Must be billed with one of the following medical checkup codes:

--99381
--99382
--99391
--99392

Reimbursed at $34.16 in addition to the Texas Health Steps checkup reimbursement.

Federally qualified health centers and Rural Health Centers do not receive additional encounter

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

OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.

OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.

Documentation must include all components of the OEFV.

Documentation Criteria

- Must document all components of OEFV on the documentation form provided during the training.
- Keep record of the referral to a dental home.

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

OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.

OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.

Documentation must include all components of the 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.

Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member's Main Dental Home choice in the Members' file.

CHIP Non-emergency Dental Services:

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

Parkland Community Health is **responsible** for paying for treatment and devices for craniofacial anomalies.

Coordination with Non-Medicaid Managed Care Covered Services

In addition to Parkland Community Health Plan's coverage, STAR members are eligible for the services described below. Parkland Community Health and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM); list is not all-inclusive. Please see TMPPM for more information and an all-inclusive list.

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Department of State Health Services (DSHS) Targeted Case Management (non-capitated service coordinated by LMHAs until August 31, 2014)
- DSHS Mental health rehabilitation (non-capitated until August 31, 2014)
- Case Management for Children and Pregnant Women
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Health and Human Services Commission's Nonemergency Medical Transportation (NEMT) Services (Parkland Community Health will use HHSC's provided language -Attachment E.)
- HHSC hospice services
- Admissions to inpatient mental health facilities as a condition of probation for STAR, Texas Health Steps Personal Care Services for Members birth through age 20
- HHSC contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities
- HHSC contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities

Pharmacy Benefit Program

PCHP administers the Pharmacy Benefit Program, effective March 1, 2012. PCHP 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. PCHP 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 PCHP 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

Parkland Community Health allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

Attention female members:

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Pregnancy Notification Requirements

Pregnant STAR Members

PCHP 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 case management in order to help in maintaining a healthy full-term pregnancy.

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage in 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 Health	STAR Health	STAR Health	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.
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
Alberto N

Alberto N First Partial Settlement Agreement

The Alberto N First Partial Settlement Agreement with HHSC requires the HMO to notify Members when the HMO is reducing, denying, or terminating a requested Medicaid service on the basis that the service is not medically necessary or federal financial participation is not available, and when the HMO receives incomplete prior authorization requests. Notices must substantially conform to the sample notices in the HHSC Uniformed Managed Care Manual and must be written at a 6th grade reading level with the exception of citations, medical terms, policy, or law. This process only applies to STAR and STAR Kids /Medicaid Members under the age of 21.

Notification for Reduction, Denial, Termination of Services Due to no Federal Financial Participation

The notice informing the Member of a reduction, denial, or termination of a requested service because there is no federal financial participation for the requested service shall:

a. state that this is the basis;

b. contain an explanation of the basis for the HMO's decision, applying the state or federal law to the individual's particular request; and

c. cite the particular federal law that prohibits federal financial participation for the requested service.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action the HMO intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the basis for the HMO's decision, applying the state and/or federal law to the individual's request;
- A cite to the particular federal law that prohibits federal financial participation for the requested service;
- A toll-free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a State Fair Hearing;
- Information about accessing medical case management; and
- An explanation of:
    - The individual's right to a State Fair Hearing;
    - The number of days and date by which the State Fair Hearing must be requested;
    - The individual's right to represent him or herself, or use legal counsel, a relative, friend, or other spokesman;
    - The right to either a written, telephonic, or in-person hearing;
    - The right to examine, at a reasonable time before the date of the hearing, the contents of the case file, and any and all documents to be used by the HMO at the hearing; and,

- The circumstances under which services will be continued if a hearing is requested.

Notification for Reduction, Denial, Termination of Services Not Medically Necessary

The notice informing the Member of a reduction, denial, or termination of a requested service, based on a determination that the requested service is not medically necessary, shall:

- State that this is the basis;
- Contain an explanation of the medical basis for the HMO's decision, applying the HMO's policy or the accepted standards of medical practice to the individual's particular medical circumstances; and
- Cite the particular state and federal law that supports, or the change in state or federal law that requires, the intended action.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances;
- A cite to the particular state and federal law that supports, or the change in state or federal law that requires, the intended action;
- A toll-free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a State Fair Hearing;
- Information about accessing medical case management; and,
- An explanation of:
  - The individual's right to an appeal and information on how to request an appeal;
  - The Individual's right to a State Fair Hearing;
  - The number of days and date by which the State Fair Hearing must be requested;
  - The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
  - The right to either a written, telephonic, or in-person hearing;
  - The right to either examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing, and
  - The circumstances under which services will be continued if a hearing is requested.

Notification for Incomplete Prior Authorizations

When a request for prior authorization is submitted to the HMO or its contractor with incomplete specific documentation/information the HMO or its contractor will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, or when possible, the HMO or its contractor will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process.

STAR Members 21 Years Old and Over

If the documentation/information is not provided within one (1) Business Day of its request by the Medicaid provider, the authorization will be administratively denied for incomplete information. A letter will be sent to the requesting and referring provider indicating denial for lack of information.

SECTION D
Texas Health Steps

What is Texas Health Steps?

THSteps is a children's benefit under Texas Medicaid which provides medical and dental preventative care and treatment to Medicaid clients from birth through 20 years of age. The program is designed to improve the health of Texas kids. For full information on the Texas Health Steps and Comprehensive Care Program, including private duty nursing, prescribed pediatric extended care centers, and therapies, please see the Texas Medicaid Provider Procedures Manual at: TMPPM More information about the THSteps program and its requirements is found at Appendix M.

For more information about THSteps, please refer to the Texas Health Steps website at http://www.dshs.state.tx.us/thsteps/

How Can I Become a Texas Health Steps Provider?

All PCHP Primary Care Providers (PCPs) must enroll to become a Texas Health Steps provider. If a provider wishes to become a THSteps provider, he/she can go to www.tmhp.com and click on Provider Enrollment. This page will allow providers to complete the THSteps Enrollment Application, as well as other applications such as the Dental Provider Enrollment Application and the Children with Special Healthcare Needs (CSHCN) Provider Enrollment Application. If you have any questions, please contact TMHP at (800) 925-9126, Option 2. Completed applications should be mailed to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
P.O. Box 200795
Austin, Texas 78720-0795

Finding a Texas Health Steps Provider

You may locate a Texas Health Steps provider by reviewing your PCHP 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 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

- Checkups received before the periodic due date are not timely medical checkups.
- For reporting periods on and after September 1, 2010:
    - Member is less than 36 months of age: A checkup is considered to have been provided timely if the checkup occurs within 60 days beyond the periodic due date based on an Existing Member's birthday.
    - Member is 36 months of age or older: A checkup is considered to have been provided timely if the checkup occurs within 364 calendar Days after the child's birthday in a non- leap year or 365 calendar Days after the child's birthday in a leap year.

If a provider has documentation that a member has already received a checkup there will be no need to conduct another checkup until the next checkup is due whenever appropriate.

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

Documentation of Completed Texas Health Steps Components and Elements

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

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation. THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening

- A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

3. **Immunizations,** as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.

- Immunization status must be screened at each medical checkup and necessary vaccines such as
- pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
- The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
- Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
- Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.

4. **Laboratory tests,** as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia

- Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
- Anemia screening at 12 months.
- Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
- HIV screening at 16-18 years
- Risk-based screenings include:
    - Dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia

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

6. **Dental referral** every 6 months until

the parent or caregiver reports a dental home is established.

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

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

PCP's that are enrolled providers in the Texas Vaccines for Children (VFC) program should be provided with free vaccines for administration to Covered Persons from birth to age 18. You may enroll in the VFC program by completing the form found at (first link): http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.

PCHP will not pay PCP's for their own private stock of vaccines unless VFC posts that it does not have vaccine stock available, which you may determine by visiting its web site: http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.You are responsible for checking the TVFC web site each day, as it may replenish stocks that were previously depleted.

If TVFC was out of vaccine on the date of your vaccination of a Covered Person, you may submit a claim for the vaccines with the U-1 modifier.

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 PCHP.

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 PCHP. Members can self-refer to participating dentists in Texas Health Steps. Neither a referral from the PCP nor

authorization from PCHP 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 PCHP and will be processed and paid by PCHP for PCHP Members.

Oral Evaluation and Fluoride Varnish

Oral evaluation and fluoride varnish is covered by PCHP 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 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 and with a CPT D1208 claim line with a billed amount of $0.01 for reporting purposes. CPT D1208 indicates the varnish was applied (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 PCHP subcontractor, Superior Vision The web address is https://superiorvision.com/ 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

PCHP will conduct outreach to help in making the Texas Health Steps appointments for STAR Members. PCHP 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.

PCHP reaches out and schedules Texas Health Steps appointments for Members that are due a checkup.

Attention Deficit Hyperactivity Disorder (ADHD)

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the TMPPM. Providers should complete follow-up of members receiving these medications including a minimum of a one-month follow-up to first fill of the prescription and two subsequent OV during the next 9 months.

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.

SECTION E
STAR Appeals & Complaints

STAR Member Complaint Introduction

Member Complaints

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of PCHP's services if it is not related to an Adverse Benefit Determination. A complaint related to an Advanced Benefit Determination is considered an appeal, which is covered later in this chapter.

PCHP provides a designated Member Advocate to assist Members in understanding our complaint process. The Member Advocate assists Members in writing or filing a complaint and monitor the complaint process until the issue is resolved. PCHP resolves complaints related to all service aspects of PCHP, including services provided by subcontractors.

Complaints include but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

A PCHP member advocate is available to assist STAR members with their rights and responsibilities and the filing of complaints.

Complaints submitted to PCHP are tracked and trended, resolved within established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.

Network physicians and other professional providers understand and agree that the Texas Health and Human Services Commission (HHSC) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for STAR members.

PCHP and its providers are prohibited from discriminating and/or taking any punitive action against members or their representatives for making a complaint.

Member Complaint Process

A Member or members representative can file a complaint with PCHP verbally or by contacting a Member Advocate.

Submit a complaint by phone:

Member Service: 1-888-672-2277
TTY 711 (for members with hearing or speech loss)

Submit a complaint by email:
PCHPComplaintsandAppeals@phhs.org

Submit a complaint by mail:

Parkland Community Health Plan
Attn: Member Advocate
P.O. Box 560347
Dallas, TX 75356

Members can talk to their primary care provider (PCP) if they have questions or concerns about their care. If they still have questions or concerns, they should call PCHP Member Service at the number above. Translators are available for those who do not speak English. Those with hearing or speech loss may call the TTY line above.

We will help members or the person they choose to act on their behalf to solve problems or complaints about their health care. Members will not be penalized for filing a complaint.

If a member wants to file a complaint for any reason, he or she should call Member Service, fill out a complaint form, or write a letter to tell us about the problem. They can get complaint forms at the places where they get care, such as their PCP's office. Here are the things they need to tell us as clearly as they can:

- Who is part of the complaint?
- What happened?
- When did it happen?
- Where did it happen?
- Why they were not happy with their child's health care services
- Attach any documents that will help us investigate the problem

If the member cannot mail the form or letter, the member, or someone they choose to act on their behalf, can call our Member Service Department and tell us about their problem.

Acknowledgement of STAR Member Complaints

STAR members or their representative will receive an acknowledgement letter from PCHP acknowledging their complaint, unless it was an Initial Contact Complaint PCHP will send the letter within five Business Days of receipt of a member's complaint.

Resolution of STAR Member Complaints

STAR members or their representative will receive an acknowledgement letter from PCHP acknowledging their complaint, unless it was an Initial Contact Complaint PCHP will send the letter within five Business Days of receipt of a member's complaint.

STAR Member Complaints about Potential Quality of Care (PQOC) Issues

PQOC issues are reviewed by our quality team and the medical director, who assigns a severity level and makes recommendations. All practitioners are evaluated for a history of trends during the 36 months prior to the current complaint. High-risk and high-volume complaints are presented to the Clinical Quality Improvement Committee. When warranted, the CQIC presents the case to the Credentialing Committee.

Other options for filing a Complaint

How to File a Complaint with the Texas Health and Human Services Commission

If a member is still not satisfied after completing PCHP's complaint process, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

Submit a complaint by phone:

Toll-free: **877-787-8999**
TTY (for hearing and speech impaired):
800-735-2989 or National Relay Service 711

Submit a complaint by email

HPM_Complaints@hhsc.state.tx.us

Submit a complaint by mail:

Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P.O. Box 13247
Austin, TX 78711-3247

Members must exhaust the HMO's Complaint Process prior to contacting HHSC.

STAR Member Appeals

An appeal is a request by a member to have PCHP reconsider an adverse determination. Two types of appeals are explained in detail in this chapter:

- Standard Appeals- A Standard Appeal is when a STAR member or his or her authorized representative requests that PCHP reconsiders the denial of a service or payment for services, in whole or in part.
- Expedited Appeals – A member may request an Expedited Appeal when the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

PCHP provides a designated Member Advocate to assist Members in understanding and using our appeals process. The Member Advocate assists Members in writing or filing an appeal and monitor the appeal through the appeals process until the issue is resolved.

STAR Member Standard Appeals

Our Medical Management Department will notify the Member or a person acting on behalf of the Member and the Member's provider of a determination made in a utilization review. A notice of adverse benefit determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension or termination of a previously authorized service.

PCHP members have the right to appeal any services denied in whole or in part by PCHP because it was determined that they were Not medically necessary. A denial of this type is called an Adverse Benefit Determination.

An adverse determination is one type of action.

Action: The denial or limited authorization of a requested service including the following:

- Type and level of service
- Requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment of service
- Failure to provide services in a timely manner
- Failure of the health plan to act within certain time frames
- Denial of a Medicaid member's request to obtain services outside the network (for a resident of a rural area with only one managed care organization)
- Denial of a member's request to dispute a financial liability, including copayments

A STAR member or his or her authorized representative may submit an oral or written appeal regarding an Adverse Benefit Determination within 60 days from receipt of the denial letter.

With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the member or his or her authorized representative. A provider may appeal on the members behalf with written consent.

The member and his or her authorized representative are given an opportunity, before and during the appeal process, to examine the Member's case file, including medical records and any other documents considered during the appeal process. PCHP will inform the member of the timeline available for providing additional information and that limited time is available for expedited appeals.

When the appeal is the result of a medical necessity determination, a Medical Director of the same or similar specialty and who was not involved in the initial decision reviews the case. The Medical Director contacts the provider, as necessary, to discuss possible alternatives.

Appeals should be submitted to PCHP at the following address:

Parkland Community Health Plan
Attn: Member Advocate
P.O. Box 560347
Dallas, TX 75356

Acknowledgement of STAR Member Appeals

STAR members will receive an Acknowledgement Letter from PCHP acknowledging their appeal. PCHP will send the letter within five Business Days of receipt of a member's appeal.

Response to STAR Member Appeals

Once an oral or written appeal request is received, the case is investigated by the Complaints and Appeals Unit. PCHP may request medical records or a physician or other professional provider explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians and other professional providers are expected to comply with the request for additional information within 10 calendar Days.

If the information requested from the provider is not submitted to PCHP within 16 business hours, we will send a letter to the member indicating the request cannot be acted upon until the documentation/information is provided. We will include a copy of the letter sent to the physician or other professional providers describing the documentation/information that needs to be submitted.

The services being received by the Member, including the benefit that is the subject of the appeal, will be continued if all the following criteria are met:

- The Member or his or her representative files the appeal timely as defined in the contract
- The appeal involves the termination, suspension, or reduction of a previously authorized service
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The Member or his or her representative timely requests an extension of the benefits. If, at the Member's request, PCHP continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
- The Member withdraws the appeal
- 10 days pass after PCHP mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the 10-day time frame, has requested a State Fair Hearing.
- A State Fair Hearing Officer issues a hearing decision adverse to the Member

While an appeal of medical necessity of services is pending, the provider may ask the member to sign a financial responsibility form in order to continue services during the appeal period. The member and provider may also choose to discontinue services to await the final decision. If the final determination of the appeal is in the member's favor, we will authorize coverage of and arrange for provision of the appealed services promptly and as expeditiously as the member's health condition requires. If the final determination is in the member's favor and the member received the appealed services, we will pay for those services. If the final determination is not in the member's

favor, the member may be required to pay the cost of the services furnished while the appeal was pending a final determination.

Resolution of Standard Appeals

Standard appeals are resolved within 30 calendar Days of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution, including their appeal rights within 30 calendar Days from receipt of the appeal request.

Extensions

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar Days if:

- The member or his or her representative requests an extension
- PCHP shows that there is a need for additional information and how the delay is in the member's interest

If the resolution time frame is extended for any reason other than by request of the member, PCHP will provide written notice of the reason for the delay to the member.

STAR Member Standard Appeals

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal.

PCHP will inform the member of the time available for providing information, and that limited time is available for Expedited appeals.

A STAR member may request an expedited appeal in the same manner as a standard appeal but should include Information informing PCHP of the need for the expedited appeal process.

Members may call Customer Service or write to PCHP to request an Expedited Appeal:

Request an expedited appeal by phone
Member Service
1-888-672-2277; TTY 711

Request an expedited appeal by mail
Parkland Community Health Plan
Attn: Member Advocate
P.O. Box 560347
Dallas, TX 75356

PCHP will make resources available to assist members or members representatives in filing an Appeal, to include the PCHP Member Advocate.

Timeline for STAR Members to Request an Expedited Appeal

Requests for an expedited appeal can be made verbally or in writing to PCHP as indicated in the Member Appeal Process listed above. PCHP provides a designated Member Advocate to assist Members in understanding and using our appeals process. The Member Advocate assists Members in writing or filing an Expedited Appeal and monitor the appeal through the process until the determination is made.

STAR–Acknowledgement of Expedited Appeals

Expedited appeals are acknowledged verbally, if possible, within one Business Day. PCHP will follow up in writing with a resolution within 72 hours.

If PCHP denies a request for an expedited appeal, PCHP must:

Transfer the appeal to the timeframe for standard resolution.

Make a reasonable effort to give the member prompt oral notice of the denial and follow up within two calendar Days with a written notice.

Response to Expedited Appeals

PCHP may request medical records or a physician or other professional provider

explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians or other professional providers are expected to comply with the request for additional information with in one Business Day.

Resolution of Expedited Appeals

PCHP resolves expedited appeals as quickly as possible and within three Business Days. The member is notified by telephone of the resolution, if possible, and a written resolution is sent. However, if the appeal is for an ongoing emergency or denial of continued hospitalization, the appeal will be completed according to the medical or dental immediacy of the case but not later than one Business Day after the request for the expedited appeal is received.

Specialty Provider Reviews

When an appeal is denied the provider can request for a Specialty Provider Review. The provider must make the request within 10 days and provide a good reason why the specialty review is needed. The denial will be reviewed by a health care provider who works in the same or similar specialty as the condition, procedure or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

State Fair Hearing Process

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 or her by writing a letter to the health plan telling PCHP 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 the State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at:

Parkland Community Health Plan

Attn: State Fair Hearing
P.O. Box 560347
Dallas, TX 75356

Or call **1-888-672-2277**

Timeline for STAR Members to Request a State Fair Hearing

If the Member asks for a State Fair Hearing within 10 Days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within10 Days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

Response to STAR Member Request for a State Fair Hearing

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

Resolution of STAR Member Request for a State Fair Hearing

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

If the hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, PCHP will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If such a decision was made by the hearing officer and the member received the disputed services while the appeal was pending, PCHP will be responsible for payment of services.

PCHP members have the right to access the State Fair Hearing process AFTER they have exhausted their appeal rights with PCHP.

STAR Provider Complaints and Claim Appeal Process

Physician and other professional provider complaints and appeals are classified into categories for processing by PCHP as follows:

- Complaints relating to the operations of PCHP
- Physician and other professional provider appeals related to Adverse Determinations
- Physician and other professional provider appeal of non-medical necessity claims determinations

Complaints Relating to the Operations of PCHP

Physicians and other professional providers may file written complaints involving:

- Dissatisfaction or concerns about another physician and other professional providers
- Operation of PCHP
- Members, if the complaints are not related to a claim determination or Adverse Determination

Complaints related to claim determination or Adverse Determination should be submitted in accordance with the procedures set forth later in this section.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider.

Complaints submitted to PCHP are tracked and trended, resolved within established time frames and referred to peer review if needed.

PCHP may request medical records or an explanation of the issues raised in the complaint by telephone or a signed and dated letter by fax or mail. Providers are expected to comply with the request for additional information within 10 calendar Days.

Providers are notified in writing of the resolution of the complaint including the process to file a complaint with HHSC when the Provider is not satisfied with PCHP's decision. Findings or decisions of peer review or quality of care issues are not disclosed.

Network providers understand and agree that the Texas Health and Human Services Commission (HHSC) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for STAR CHIP members.

Physician and other professional provider complaints relating to operational issues may be faxed or submitted to the following address:

Parkland Community Health Plan
Attn: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356

Fax: 844-310-1823
Provider Portal
www.parklandhealthplan.com

The complaint must include the provider's name, date of the incident, and a description of the incident.

Providers may also submit provider appeals through the provider portal at www.parklandhealthplan.com

A Complaints and Appeals Representative receives and logs the physician and other professional provider's complaint and sends an acknowledgement letter to the provider within five Business Days of receipt of the complaint. The Complaints and Appeals representative will investigate the provider complaint and respond to the provider in writing within30 calendar Days of receipt of the complaint. Including the process to file a complaint with HHSC when the Provider is not satisfied with PCHP's decision. Findings or decisions of peer review or quality of care issues are not disclosed.

PCHP stores all the documentation related to Providers Complaints in a digital database. This includes retention of fax cover pages, emails to and from PCHP and maintaining a log of telephone communications

STAR—Provider Appeals Related to Adverse Benefit Determinations

A STAR member's provider of record may submit an Adverse Determination appeal in accordance with the procedures set forth in STAR Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the provider is unable to obtain the member's

consent, a provider may use the Provider Claims and Appeal Process procedures outlined in the Claims and Billing Chapter.

Provider Appeals of Non-Medical Necessity Claims Determinations

A physician or other professional provider may appeal a decision regarding payment for any service NOT related to Non-medical necessity determinations. For these appeals, the physician or other professional provider should follow the Provider Claim Payment Reconsideration Process.

Provider Complaint Process through the Texas Health and Human Services Commission (STAR)

A Provider who believes that they did not receive full due process from PCHP may file a Complaint with HHSC. HHSC is only responsible for management of the Complaints. Appeals, hearing or dispute resolutions are the responsibility of PCHP. Providers must exhaust the Complaint process with PCHP before filing a Complaint with HHSC. Complaints must be in writing and received by HHSC within sixty (60) calendar Days from PCHP's notification of final action. Providers should refer to the Texas Medical Provider Procedures Manual for additional information, and mail Complaints to the following addresses:

(For Medicaid claims)
Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
P.O. Box 85200
Austin, TX 78708
Email: HPM_Complaints@hhsc.state.tx.us (for CHIP claims)

Provider Claim Payment Appeal Procedure

Claim Payment Appeals is the process by which a provider may challenge the disposition of a claim that has already been adjudicated. Provider appeals include, but are

not limited to:

- Payer allowance
- Medical policy or medical necessity
- Incorrect payment/coding rules applied

Provider appeals are not considered:

- Corrected claim

- General inquiry/question
- Claim denials needing additional information

Requests for claim payment appeals must be submitted in writing to PCHP within 120 days of a claim disposition.

Include all pertinent information.

Parkland Community Health Plan
Attn: Appeals and Complaints
P. O. Box 560347
Dallas TX 75356
Fax: 844-310-1823

Providers may also submit provider appeals through the Provider Portal Information at www.parklandhealthplan.com

Claim payment appeal requests are resolved within 30 days of receipt of written request. After the review is complete, a resolution letter with the details of our decision will be sent to the provider.

If a provider is not satisfied with the outcome of the review conducted through the Provider Appeal Process, additional steps can be taken:

1. Mediation (handled per the PCHP physician agreement)

2. Arbitration (handled per the PCHP physician agreement)

A provider who believes that they did not receive full due process from Parkland Community Health may file a complaint with HHSC. HHSC is only responsible for management of the complaints. Appeals, hearing or dispute resolutions are the responsibility of Parkland Community Health. Providers must exhaust the complaint/appeal process with Parkland Community Health before filing a complaint with HHSC. Providers should refer to the Texas Medical Provider Procedure's Manual for specific information on complaint requirements. Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Health Plan Operations, H-320
Resolution Services
P.O. Box 85200
Austin, TX 78708-5200
Email: HPM_Complaints@hhsc.state.tx.us

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and Member complaints.

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

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

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that 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. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

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

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box 149104
Austin, Texas 78714-9104

Provider Claim Payment Reconsideration

Provider Claim Payment Reconsideration Process

If you disagree with the outcome of a claim, you may utilize the PCHP provider payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

Please be aware there are four common, claim-related issues that are not considered claim payment reconsiderations. To avoid confusion with claim payment reconsiderations, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when PCHP requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- Member medical necessity appeals: a pre-service appeal for a denied service
- Provider medical appeals: a post-service medical appeal for a denied service

For more information on each of these, please refer to the appropriate section in this chapter of the provider manual.

The PCHP provider claim payment reconsideration process consists of two internal options. You will not be penalized for filing a claim payment reconsideration, and no action is required by the member.

1. **Claim payment reconsideration:** This is a convenient option in the PCHP provider claim payment dispute process. The reconsideration is an initial request for an investigation into the outcome of the claim. Most issues are resolved with a claim payment reconsideration.

A claim payment dispute may be submitted for multiple reason(s), including:

- Denial for no authorization obtained
- Other health insurance denial
- Claim code editing
- Duplicate claim
- Retro-eligibility
- Experimental/investigational procedure
- Claim data

2. Claim Payment Disputes (Corrected Claim/Reconsideration)

The Claim Payment Dispute is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a dispute without a finalized claim on file.

We accept claim payment disputes in writing within 95 calendar Days from the date on the Explanation of Payment (EOP) (see below for further details on how to submit).

Reconsiderations filed more than 95 calendar Days from the EOP will be considered untimely and denied unless good cause can be established.

When submitting disputes, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. Or you may utilize the PCHP Claim Payment Dispute Form located in the Provider forms section of the PCHP website.

Resolution

If the decision to deny the claim payment dispute results in a denial, We will send you an explanation of payment, which will include:

A response of what action PCHP has taken.

- The reason for the action.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar Days of the date of the reconsideration determination letter or 120 calendar Days from the original EOP if later.
- How to submit a claim payment appeal.

If the decision results in a claim adjustment, any payment and the EOP will be sent separately.

ALL Claim Disputes (Corrected Claims and Reconsiderations) MUST BE SUBMITTED TO:

Parkland Community Health Plan
Claims Dispute
P.O. BOX 560327
DALLAS, TX 75356

SECTION F
STAR Member Rights and Responsibilities

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 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 a State Fair Hearing from the state Medicaid program and get information about how the 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 Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.

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2. You must follow all rules and regulations affecting your NEMT services.

3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.

4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.

5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the buss tickets or tokens only to go to your medical appointment.

6. You must only use NEMT Services to travel to and from your medical appointments.

7. If you have arranged for an NEMT Service but something changes, an you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

Children's Health Insurance Program (CHIP)

CHIP Program
SECTION A
CHIP 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 PCHP Member Services at 1-888-814-2352 TTY 711

Verification of Eligibility

To confirm member eligibility Providers may contact PCHP at 1-888-814-2352 or visit the PCHP website at www.parklandhealthplan.com. Currently, Members are enrolled for a twelve (12) month period, or as stated above for CHIP Perinate Newborn members.

PCHP issues a CHIP Member ID card.

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 PCHP 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

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.

Verification of Eligibility by Pharmacies

Pharmacies may verify eligibility electronically via NCPDP E1 Transaction.

Enrollment Process

CHIP and CHIP Perinatal eligibility is for 12 continuous months. HHSC or Maximus, the Administrative Services Contractor, presents health plan options to individuals and families eligible for STAR or CHIP. STAR or CHIP eligible members enroll in the managed care plan of their choice and select a primary care provider or primary care site (PCS). If HHSC does not receive this enrollment information within 45 Business Days, it assigns the member to a STAR plan, and then submits the member information to PCHP. We then assign a PCP or for the member.

CHIP eligible members must enroll in a CHIP health maintenance organization (HMO) plan in 90 Business Days or they will not be eligible for CHIP services. CHIP eligible members are not defaulted into a plan.

HHSC or Maximus informs PCHP of new member enrollment and notifies PCHP after enrollment of any changes in member eligibility, status or contact information (such as change of address).

Physicians and other professional providers will be given notice of new members signed up or assigned to their care through monthly eligibility reports mailed to them by PCHP.

PCHP sends each new member an enrollment kit within five Business Days after receiving the HHSC monthly membership file. This includes a member identification (ID) card, letter and PCP choice or assignment. The ID card includes PCP contact information as well as the procedures for changing a PCP.

HHSC will automatically re-enroll any member who loses STAR or CHIP eligibility but becomes eligible again within six months or less. Members will automatically return to the same health plan and PCP as they had prior to disenrollment, if available. Members may choose to switch plans.

To support the member enrollment process, PCPs are encouraged to maintain open panels. The state requires that 90 percent of PCHP PCPs have open panels, and your open panel will assist us in meeting this requirement.

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

CHIP members may request a change:

- For any reason within 90 Business Days of CHIP enrollment and once there after
- For cause at any time
- If the member moves to a different service delivery area
- During the annual re-election period

HHSC will make the final decision

Disenrollment from Health Plan

Disenrollment from the CHIP/CHIP Perinatal Program occurs due to loss of eligibility, including, but not limited to the

following events:

- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

HHSC will make the final decision.

Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

When a CHIP member switches from his or her Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage, it does not count as their one Managed Care Organization plan change per year. Members may request a change in their Managed Care Organization for exceptional reasons or good cause.

Who Can Initiate Disenrollment?

Two sources may initiate a disenrollment:

- The member
- PCHP

Member-Initiated Disenrollment

Members can voluntarily disenroll and choose another managed care health plan at any time, except during an inpatient stay. When members enroll in our plan, we provide instructions on where to call or write to disenrolled and choose another managed care health plan. Disenrollment become effective the first Business Day of the second month

after Texas Health and Human Services Commission (HHSC) or a contract or receives all documentation necessary as determined by HHSC.

Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

Disenrollment may result in any of the following:

- Enrollment with another plan
- Termination of eligibility

If a member asks a physician or other professional how to disenroll from PCHP, the physician or other professional provider can direct the member to call the Member Service phone number on the back of the member's identification (ID) card: at 1-888-814-2352

Plan-Initiated Member Disenrollment

PCHP may request disenrollment for a member who has moved out of the service area. If members move out of the service area, they are responsible for notifying their state eligibility worker of the address change. After that, HHSC will disenroll the member from the health plan.

PCHP may also request disenrollment if:

- The member misuses or loans their membership card to another person
- The member is disruptive, unruly, threatening or uncooperative
- The member refuses to comply with managed care restrictions

State Agency–Initiated Member Disenrollment

PCHP receives daily changes and monthly full replacement files from HHSC and contracted agencies containing all active membership

data and incremental changes to eligibility records. PCHP disenrolls member who are not listed on the monthly full replacement file effective as of the designated disenrollment date with consideration of the following disenrollment reasons:

- Death
- Permanent change of residence out of service area
- County changes
- Loss of benefits
- Voluntary disenrollment
- Change in eligibility status
- Incarceration
- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Member has other non-government or government sponsored health coverage

Pregnancy Notification Requirements

When seeing a member who is pregnant, including a pregnant teen, remind her of the importance of calling both DSHS and PCHP to report the pregnancy. We offer a prenatal program that will assist her during pregnancy.

We require network providers to notify the plan immediately upon identifying a pregnant CHIP member (excluding CHIP Perinatal). Pregnant CHIP members may be referred for a Medicaid eligibility determination. Those pregnant CHIP members who are determined to be Medicaid-eligible will be disenrolled from CHIP. Medicaid coverage will be coordinated to begin when CHIP enrollment ends to avoid gaps in health care coverage. If we remain unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP. The member's eligibility expiration date will be the latter of:

- The end of the second month following the month of the baby's birth
- The member's original eligibility expiration date

Newborn Process

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

SECTION B
CHIP Covered Services

Medically Necessary Services

For CHIP members, nonbehavioral health-related health care services that are:

- Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life.
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
- Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies.
- Consistent with the member's diagnoses.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency.
- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

For CHIP members, behavioral health services that:

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

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

CHIP and CHIP Perinate Newborn Covered Services

"Spell of illness" limitation removed

Members of the Parkland Community Health Medicaid program members are not limited by the "spell of illness" limitation, which is specified in the current Texas Medicaid Provider Procedures Manual. The annual limit of $200,000 on inpatient services does not apply for Medicaid Members.

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	• 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
	outpatient services • 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: o dilation and curettage (D&C) procedures; o appropriate provider administered medications; o ultrasounds; and o 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: o cleft lip and/or palate; o severe traumatic skeletal and/or congenital craniofacial deviations; or o 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

		• 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
		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

	○ 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 • 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		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
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 termination of services must be presented to the court with jurisdiction over the matter for determination	Applicable level of co-pay applies to office visits

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		• 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 education, and crisis	

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		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 authorizatio n • 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.		
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: • Physical, occupational and speech therapy • Developmental assessment	Required prior authorization and doctor prescription	Co-pays do not apply
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

Type of Benefit	Description of Benefit	Limitations	Co-Pay
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 • Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye	Applicable level of co- pay applies to office visits billed for refractive exam

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	
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 this 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/ 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
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
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are e ligible 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
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 treatments b) as part of covered home care for wound care for indwelling urinary catheter irrigation
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes
Tape			See: Dressing Supplies Ostomy Supplies IV Therapy Supplies
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage
Under Pads			See Diapers/Incontinent Briefs/Chux
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge

			when applied during office visit
Urinary, External Catheter & 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

PCHP Value Added Services * certain restrictions may apply

Value Added Services *Effective 09/01/2020*	*STAR*	*CHIP*	*CHIP PERINATE*
24 hour Nurse Line – You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about you or your child's health needs. For STAR, call: 214-266-8773 or Toll Free 1-888-667-7890 For CHIP, call: 214-266-8766 or Toll Free 1-800-357-3162	X	X	X
Pregnancy classes at no charge to members at certain places for pregnant members and their partners.	X	X	X
Medicaid Members enrolled in the Federal Lifeline Program receive a free cell phone to include data, minutes and text messaging for members. Parkland Community Health Plan Medicaid members will receive unlimited calls to Parkland Community Health Plan Member Services Free health education messages from Text4Babies, Text4Kids, Text4Health, Care4Life, and Text2Quit.	X		
Adult Dental Services: Up to $300, per year for dental checkups, x-rays and cleaning for members 21 and older	X		
Vision Services: $150 yearly allowance, towards upgrades on frames for members	X	X	
Sports Physical: 1 sports physical each school year for members ages 3 to 19	X	X	
Sign up for Parkland Community Health Plan's Be In Control Program for **educational materials for asthma and diabetes**	X	X	
Gym membership for 6 months to current members ages 13-20 with a diagnosis of obesity, yearly	X	X	
200 points ($20 value) for first time member enrollment into the online Member Portal at www.parklandhealthplan.com	X	X	
200 points 20 value) annually for members who complete a behavioral health follow up within 30 days after hospitalization for a behavioral health diagnosis	X	X	
200 points ($20 value) for the completion of each timely Texas Health Steps checkups for ages 2 months; 4 months; and 6 months	X	X	
250 points ($25 value) for the completion of each timely well child checkups for ages 9 months; 12 months; and 15 months	X	X	
250 points ($25 value) to members ages 12 to 18 who complete a timely Texas Health Steps checkup	X	X	
250 points ($25 value) annually for members who receive annual flu shot	X	X	X

250 points ($25 value) annually to new members who complete a PCP visit within 90 days of joining the health plan	X	X	
250 points ($25 value) annually for members age 10+ who complete the 3-week Step-Up Challenge	X	X	
250 points ($25 value) annually for members receiving initial medications for ADHD and who received a follow-up visit within 30 days of joining Parkland Community Health Plan	X	X	
250 points ($25 value) annually for completion of chlamydia screening	X	X	
300 points ($30 value) annually for members who complete a behavioral health follow up within 7 days after hospitalization for a behavioral health diagnosis	X	X	
300 points ($30 value) annually for being enrolled in the Be In Control Program for 3 months	X	X	
400 points ($40 value) annually for completion of prenatal checkup within the 1st trimester or within 42 days of joining Parkland Community Health Plan	X	X	X
500 points ($50 value) annually for being enrolled in the Be In Control Program for 6 months	X	X	
Up to 600 points ($60 value) annually for asthma medication refills	X	X	
600 points ($60 value) per pregnancy for members who receive their postpartum checkup within 21-56 days of delivery, while enrolled in Parkland Community Health Plan	X		
250 points ($25 value) annually for STAR members who follow-up with their primary care provider within 7 days of a hospital discharge	X		

****Limitations and restrictions apply for each Value Added Service.****

Members must be enrolled with Parkland Community Health Plan at the time of the checkups, exams and/or test.

Non-CHIP Covered Services (Non-Capitated Services)

Non-CHIP Covered Services include the following:

Texas Agency Administered Programs and Case Management Services

Texas Department of Protective and Regulatory Services (TDPRS):

PCHP 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 PCHP 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 Business 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 PCHP Case Management.

Essential Public Health Services

PCHP 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 PCHP 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.

PCHP 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, PCHP will no longer reimburse providers for private stock when the TVFC stock is replenished.

Pharmacy Benefit Program

PCHP 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. PCHP is however, responsible for assisting its Members with medication management through the PCPs and/or Specialty Care Physicians.

Co-Pay Information for CHIP Members

There is no co-pay for:	There is no co-pay for:
▪ Native Americans ▪ CHIP Perinate Members, or ▪ CHIP Perinate Newborns.	▪ Well-baby checkups ▪ Well-child checkups ▪ Preventative checkups, or ▪ Pregnancy-related services

CHIP Cost Sharing Schedule CHIP Cost Sharing	
Enrollment fees (for 12-month enrollment period)	**Charge**
At or below 151 percent of FPL*	$0
Above 151 percent up to and including 186 percent of FPL	$35
Above 186 percent up to and including 201 percent of FPL	$50
Copays (per visit):	
At or below 151 percent of FPL	**Charge**
Office visit (non-preventative)	**$5**
Nonemergency ER	**$5**
Generic drug	**$0**
Brand drug	**$5**
Facility copay, inpatient (per admission)	**$35**
Cost-sharing cap	**5 percent (of family's income)****
Above 151 percent up to and including 186 percent of FPL	**Charge**
Office visit (non-preventative)	**$20**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug	**$35**
Facility copay, inpatient (per admission)	**$75**
Cost-sharing cap	**5 percent (of family's income)****
Above 186 percent up to and including 201 percent of FPL	**Charge**
Office visit (non-preventative)	**$25**
Nonemergency ER	**$75**
Generic drug	**$10**
Brand drug	**$35**
Facility copay, inpatient (per admission)	**$125**
Cost-sharing cap	**5 percent (of family's income)****

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

Member's Right to Designate an OB/GYN

Parkland Community Health allows the member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

Attention female members:

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition

A referral to a specialist doctor within the network

SECTION C
Well Child Exams

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 Business Days of becoming a Parkland 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 Complaints & Appeals

CHIP Member Complaints

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of PCHP's services if it is not related to an Adverse Determination. A complaint related to an Advanced Determination is considered an appeal, which is covered later in this chapter.

We will help PCHP members solve problems or complaints about their healthcare. PCHP resolves complaints related to any aspect of service provided by PCHP or any subcontractor providing services on behalf of PCHP.

Complaints include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business.

PCHP Member Service can assist CHIP members with filing complaints.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Complaints submitted to PCHP are tracked and trended, resolved with in established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.

Network physicians and other professional providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for Medicaid (CHIP) members.

PCHP and its providers are prohibited from discriminating and/or taking any punitive action against a member or his or her representative for making a complaint.

Members who are not satisfied with PCHP's resolution of their complaint may file a complaint with the TDI. These procedures are outlined in this chapter.

CHIP Member Complaint Process

HOW TO FILE A COMPLAINT

A member, or someone they choose to act on their behalf, may call Member Service or mail the complaint in writing.

Submit a complaint by phone
Member Service: 1-888-814-2352
TTY 711 (for members with hearing or speech loss)

Submit a complaint by email:
PCHPComplaintsandAppeals@phhs.org

Submit a complaint by mail
Parkland Community Health Plan
Attn: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356
Fax: 844-310-1823

Members can talk to their primary care provider (PCP) if they have questions or concerns about their care. If they still have questions or concerns, they should call PCHP Member Service at the number above. Translators are available for those who do not speak English. Those with hearing or speech loss may call the TTY line above.

We will help members or the person they choose to act on their behalf to solve problems or complaints about their health care. Members will not be penalized for filing a complaint.

If a member wants to file a complaint for any reason, he or she should call Member Service, fill out a complaint form, or write a letter to tell us about the problem. They can get complaint forms at the places where they get care, such as their PCP's office. Here are the things they need to tell us as clearly as they can:

- Who is part of the complaint?
- What happened?
- When did it happen?
- Where did it happen?
- Why they were not happy with their child's health care services
- Attach any documents that will help us investigate the problem

If the member cannot mail the form or letter, the member, or someone they choose to act on their behalf, can call our Member Service Department and tell us about their problem.

Acknowledgement of CHIP Member Complaints

CHIP members or their representative will receive an acknowledgment letter from PCHP acknowledging their complaint, unless it was an Initial Contact Complaint. PCHP will send the letter within five Business Days of receipt of the member's complaint.

Resolution of CHIP Member Complaints

PCHP will investigate members' complaints to develop a resolution. The investigation includes reviews by appropriate staff of the Complaints and Appeals Unit and, if necessary, internal business units.

PCHP may request medical records or an explanation from a provider about the issues raised in the complaint in order to help resolve a complaint. Providers may be notified by PCHP by phone, mail or fax. Written correspondence to providers will include a signed and dated letter.

All providers are expected to comply with requests for additional information within 10 calendar Days.

CHIP Member Complaints about Clinical Quality Issues

PQOC issues are reviewed by our quality team and the medical director, who assigns a severity level and makes recommendations. All practitioners are evaluated for a history of trends during the 36 months prior to the

current complaint. High-risk and high-volume complaints are presented to the Clinical Quality Improvement Committee. When warranted, the CQIC presents the case to the Credentialing Committee.

How long will it take to investigate and resolve my Complaint?

The member will get a complaint resolution letter within 30 calendar Days of the date we get their complaint. The letter will:

- Describe their complaint
- Tell what will be done to solve their problem
- Tell how to ask for an internal appeal of our decision

CHIP Member Complaint Appeals

When do members have the right to ask for a complaint appeal?

If a member would like to file a complaint appeal about how we resolved their complaint, the member must tell us within 30 calendar Days after they get the complaint resolution letter. The complaint appeal must be filed in writing.

Complaint Appeals Not Involving Ongoing Emergencies or Continued Hospitalization

The Complaint Appeal Panel is composed of an equal number of PCHP staff members, physicians or other Professional providers, and members. The physicians or other professional providers on the Complaint Appeal Panel must have experience in the area of care that is in dispute and must be independent of any provider who made any previous determination.

If specialty care is in dispute, the Complaint Appeal Panel must include a person who is a specialist in the field of care to which the appeal relates. PCHP members on the Complaint Appeal Panel may not be employees of PCHP.

No later than the fifth Business Day before the Complaint Appeal Panel is to meet, PCHP will provide the claimant or the claimant's designated representative with any documentation to be presented to the Complaint Appeal Panel by PCHP, the date of the Appeal Panel meeting, and the specialization of any physicians or other professional providers consulted during the investigation and the name and affiliation of each PCHP representative on the Complaint Appeal Panel.

The complainant or complainant's authorized representative is entitled to appear in person before the Complaint Appeal Panel, present alternative expert testimony and request the presence of and question any person responsible for making the disputed decision.

Complaints filed concerning dissatisfaction or disagreements with an Adverse Determination are addressed in the CHIP section of this manual on CHIP Member Appeals of Adverse Determinations.

Resolution of the Complaint Appeal

We will send the member a letter that tells them the final decision of the complaint appeal panel within 30 days of their request.

If a member is not happy with our decision, and the complaint appeal process is complete, they may file for a review by the Texas Department of Insurance. The member, or someone they choose to act on their behalf, may write to:

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box149104
Austin, TX 78714-9104

Complaint Appeals Involving Ongoing Emergencies or Continued Hospitalization

If the complaint appeal concerns an ongoing emergency or a denial of continued hospital stay that does not involve an Adverse Determination, PCHP will investigate and resolve the complaint in accordance with the medical immediacy of the case but no later than one Business Day after the receipt of the complaint.

At the member's request and in lieu of an appeal panel, PCHP will have a physician or other professional provider who works in the same specialty review the issues raised in the appeal. This professional health care provider will be reviewing the case for the first time. The reviewing physician or provider may interview the member or the member's authorized representative.

The reviewing physician or other professional provider will make a decision and give written notice of the decision to the Member or the member's authorized representative within three calendar Days of the decision.

Other Options for Filing Complaints

CHIP Member Complaint to the Texas Department of Insurance

After exhausting PCHP's complaint appeal process, if a CHIP member is still dissatisfied with the decision, the member may file a complaint with the Texas Department of Insurance at:

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box149104
Austin, TX 78714-9104

Standard Appeals Questions and Answers

How will members find out if services are denied?

We may review some of the services the child's doctor suggests. We may ask the doctor why the child needs some services. If we do not approve a service the child's doctor suggests, we will send the member and the doctor a letter stating why it was denied.

What can members do if their doctor asks for a service for them that's covered, but PCHP denies or limits it?

If we deny or limit a doctor's request for service coverage, we will send the member a letter telling them how they can appeal our decision. The member or the child's doctor can appeal a denial of medical service or payment for service.

Call the Member Service line to learn more:

Member Service 1-888-814-2352
TTY (for members with hearing or speech loss) 711

PCHP will make resources available to assist members or members representatives in filing an Appeal, to include the PCHP Member Advocate.

Do member requests have to be in writing?

We will take an oral or written request for an

appeal. With the exception of expedited appeals, all oral appeals will be followed up with a request for written confirmation by the member or his or her authorized representative.

Members have the right to have someone they trust act on their behalf and help them with their appeal request. Confidentiality is maintained throughout the process. The member, or someone they choose to act on their behalf, may ask for a complaint appeal in writing to:

Parkland Community Health Plan
Attn: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356
Fax: 844-310-1823

What are the timeframes for an appeal?

Members must file a request for an appeal with PCHP within 60 days after getting the Notice of Action letter. We will send the member a letter within five Business Days to let them know that we received their appeal request.

The member may supply proof, or any claims of fact or law that supports the appeal, in person or in writing. We will let the member know when to do so. We will send a letter with the final decision of our internal review within 30 days of the request.

What can a member do if they disagree with the appeal decision?

If the member still does not agree with the decision, the member r can ask for a review by an Independent Review Organization (IRO).

Expedited Appeals Questions and Answers

What is an expedited appeal?

An expedited (rush) appeal means we need to decide quickly because of the child's health status. In other words, an expedited appeal is triggered if taking the time for a standard appeal may put the child's life or health at risk.

What happens if PCHP denies the request for an expedited appeal?

If we deny a member's request for an expedited appeal, we must:

- Call the member to let them know that we denied their expedited appeal.
- Follow up within two calendar Days with a written notice.
- Let the member know what we decide within 30 days.

What can a member do if he/she disagrees with the appeal decision?

If the member still does not agree with the decision, the member or his or her doctor can ask for a review by an Independent Review Organization (IRO).

If the member has a life-threatening condition and services have not been received, the member does not have to request an appeal before requesting an independent review. This also applies if PCHP does not meet the time frames for processing the appeal.

What are the timeframes for an expedited appeal?

We must decide no later than one working day after we get a member's request.

How does a member ask for an expedited appeal?

A member or someone the member chooses to act on his or her behalf can ask for an expedited appeal orally or in writing. If the appeal request is filed over the phone, the member does not need to duplicate the request in writing.

Who can help members in filing an

expedited appeal?

We can help Members or someone they choose to act on their behalf to file their appeals. PCHP will make resources available to assist members or members

representatives in filing an Appeal, to include the PCHP Member Advocate.

Independent Review Organization Questions and Answers

What is an Independent Review Organization (IRO)?

An Independent Review Organization is an organization that has no connection to PCHP or with health care providers that were previously in your treatment or decisions made by PCHP about services that have not been provided After members exhaust their right to appeal with us, they can ask for a review of the denial by using the IRO process. The member does not have to pay for an IRO review.

Members cannot always get an IRO review. It can be used only if we decide that the covered service or treatment is not medically necessary. It cannot be requested if the service they asked for is not covered in their contract.

How does a member ask for a review by an IRO through the external review process?

The Member or someone acting on the member's behalf and the provider of record (with members written consent) have the right to request a Standard External Review through MAXIMUS within 4 months after the date of this notification. To request the standard External Review, complete the HHS Federal External Review Request Form enclosed. Mail or fax the form along with this letter directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

Or the member can submit your request online at externalappeal.com under the "Request a Review Online" heading.

Expedited IRO through the external review process

The member or an individual acting on behalf of the member, or member's provider of record (with written consent from the member) can ask that the External Review of the appeal be handled right away. If the member believes waiting for a decision would cause you harm. To ask for an expedited external review:

- The member can e-mail the request to FERP@maximus.com
- Call the Federal External review Process at 1-888-866-6205 x3326 or
- Selecting "expedited" when submitting the review request online

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

Timeframes

For standard External Review request: The MAXIMUS Federal Services examiner will contact PCHP when they receive the request for External Review. Within five (5) Business Days, PCHP will give the examiner all documents and information used to make the internal appeal decision. The member or someone acting on the member's behalf, will receive written notice of the final External Review decision as soon as possible, but no later than 45 days after the examiner receives the request for an External Review.

For expedited or fast External Review request: The MAXIMUS examiner will give PCHP and the member or the person filing on the members behalf the External Review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The member or someone acting on the members behalf, will receive the decision over the phone, but MAXIMUS will also send a written version of the decision within 48 hours of the phone call notification.

CHIP Physician and Other Professional Provider Complaints and Appeals

Physician and other professional provider complaints and appeals are classified into categories for processing by PCHP as follows:

- Complaints relating to the operations of PCHP
- Physician and other professional provider appeals related to Adverse Determinations
- Physician and other professional provider appeals of non-medical necessity claims determinations

Complaints Relating to the Operations of PCHP

- Physicians and other professional providers may file written complaints involving:
- Dissatisfaction or concerns about another physician and other professional providers
- Operation of PCHP
- Members, if the complaints are not related to a claim determination or Adverse Determination

Complaints related to claim determination or Adverse Determination should be submitted in accordance with the procedures set forth later in this section.

A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider.

Complaints submitted to PCHP are tracked and trended, resolved within established time frames and referred to peer review if needed.

PCHP may request medical records or an explanation of the issues raised in the complaint by telephone or a signed and dated letter by fax or mail. Providers are expected to comply with the request for additional information within 10 calendar Days.

Providers are notified in writing of the resolution of the complaint including their right to file a complaint with TDI. Findings or decisions of peer review or quality of care issues are not disclosed.

Network providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for CHIP members.

Physician and other professional provider complaints relating to operational issues may be submitted to the following address:

Parkland Community Health Plan
Attn: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356
Fax: 844-310-1823

The complaint must include the provider's name, date of the incident, and a description of the incident. Providers may also submit provider appeals through the Provider Portal at www.parklandhealthplan.com

A Complaints and Appeals Representative receives and logs the physician and other professional provider's complaint and sends an acknowledgement letter to the provider within five Business Days of receipt of the complaint. The Complaints and Appeals representative will investigate the provider complaint and respond to the provider in writing within 30 calendar Days of receipt of the complaint.

PCHP stores all the documentation related to Providers Complaints in a digital database. This includes retention of fax cover pages, emails to and from PCHP and maintaining a log of telephone communications.

CHIP— Provider Appeals Related to Adverse Determinations

A CHIP member's physician and other professional providers of record may submit an Adverse Determination appeal in accordance with the procedures set forth in CHIP Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the physician or other professional provider is unable to obtain the member's consent, a physician or other professional provider may use the Provider Claims and Appeal Process procedures set forth in the Claims and Billing section.

Provider Appeals of Non-Medical Necessity Claims Determinations

A physician or other professional provider may appeal a decision regarding payment for any service NOT related to Non-medical necessity determinations. For these appeals, the physician or other professional provider should follow the Provider Claims and Appeal Process procedures set forth Provider Claim Payment Appeal Procedure section.

Provider Complaint and Appeal Process through the Texas Department of Insurance (CHIP)

If the provider is dissatisfied with the resolution of the appeal for a CHIP member service, and the provider has exhausted PCHP complaints and appeals process, the provider has the right to complain through TDI at:

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email ConsumerProtection@tdi.state.tx.us

Provider Claim Payment Appeal Procedure

Claim Payment Appeals is the process by which a provider may challenge the disposition of a claim that has already been adjudicated. Provider appeals include, but are not limited to:

- Payer allowance
- Medical policy or medical necessity
- Incorrect payment/coding rules applied

Provider claim appeals are not considered:

- Corrected claim
- General inquiry/question
- Claim denials needing additional information

Requests for claim payment appeals must be submitted in writing to PCHP within 120 days of a claim disposition. Include all pertinent information.

Parkland Community Health Plan
Attn: Appeals and Complaints
P. O. Box 560347
Dallas TX 75356
Fax: 844-310-1823

Providers may also submit provider claim appeals through the Provider Portal at www.parklandhealthplan.com and call provider services for any questions 888-814-2352

Claim payment appeal requests are resolved within 30 days of receipt of written request. After the review is complete, a resolution letter with the details of our decision will be sent to the provider.

If a provider is not satisfied with the outcome of the review conducted through the Provider Appeal Process, additional steps can be taken:

1. Mediation (handled per the PCHP physician agreement)

2. Arbitration (handled per the PCHP physician agreement)

PCHP stores all the documentation related to Provider Claim Appeals in a digital database. This includes retention of fax cover pages, emails to and from PCHP and maintaining a log of telephone communications

A provider who believes that they did not receive full due process from Parkland Community Health may file a complaint with TDI. Providers must exhaust the complaint/appeal process with Parkland Community Health before filing a complaint with TDI. Providers should refer to the Texas Medical Provider Procedure's Manual for specific information on complaint requirements. Complaints to TDI should be mailed to the following address:

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email ConsumerProtection@tdi.state.tx.us

The network provider understands and agrees that TDI reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and Member complaints.

SECTION E
CHIP Member Rights and Responsibilities

Member (Covered Person) Rights

- 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.
- Your health plan must inform 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."
- You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
- You have a right to know how the health plan decides about 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.
- You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
- 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.
- If your 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.
- Children who are diagnosed with special health care needs or a disability have the right to special care.
- 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.
- 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.
- 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 Covered Persons.
- You have the right and responsibility to take part in all the choices about your child's health care.

- You have the right to speak for your child in all treatment choices.
- You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
- You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
- 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.
- You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, inform you if they think your doctor or the health plan was right.
- You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- You have the right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member (Covered Person) Responsibilities

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

- You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
- You must become involved in the doctor's decisions about your child's treatments.
- 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.
- If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
- You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
- 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.
- If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have co-payments for that child.
- You must report misuse of the CHIP or CHIP Perinatal services by health care providers, other Members, or health plans.
- Talk to your child's provider about all your child's medications.

Parkland Community Health/Provider coordination

Parkland Community Health will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. We will provide information, education and training programs to Members, families, primary care providers, specialty physicians, and Community Agencies about the care and treatment available within Parkland Community Health for Members with disabilities or chronic or complex conditions. Specialists may function as a primary care provider for treatment of Members with chronic/complex conditions when approved by Parkland Community Health.

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of ethnicity, sex, age, religion, color, mental or physical disability, national origin, marital status, sexual orientation, or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV positive status). All participating physicians and health care professionals may also have an obligation under the Federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

For each person with disabilities or chronic or complex conditions, the Primary Care Provider is required to develop a plan of care that meets the special preventive, primary acute care and specialty care needs of the Member. The plan must be based on:

- Health needs
- Specialist recommendations
- Periodic reassessment of the Member's functional status and service delivery needs.

The Primacy Care Provider must maintain an initial plan of care in the medical records of persons with disabilities or chronic or complex conditions and that plan must be updated as often as the Member's needs change, but at least annually.

Parkland Community Health will ensure the members with special health care needs have adequate access to primary care providers and specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist members with special health care needs, their families and health care providers to facilitate access to care, continuity and coordination of services.

Reading/grade level consideration

Adhering to the policies and procedures set by HHSC, any literature that is published for informational use by Parkland Community Health Plan Members needs to be written at or below a 6th grade reading level and in English and Spanish. This will help to enhance the communication between the population, providers and Parkland Community Health Plan.

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.

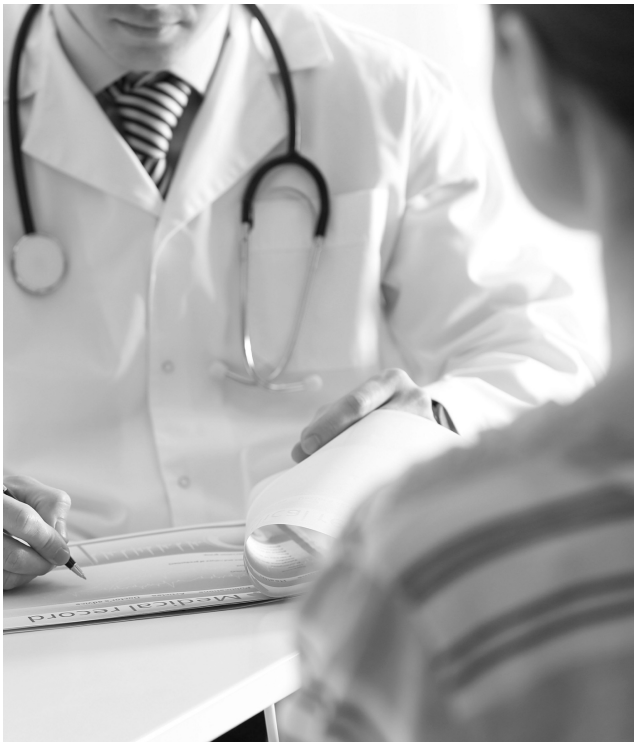
For the CHIP Perinate (Mother), the Covered Benefits are limited.

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?

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

- Placing the patient's health or, with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy
- Causing serious impairment to bodily functions
- Causing serious dysfunction to any bodily organ or part

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

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

PCHP 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.

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

- 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.
- You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
- 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.
- You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
- 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.
- 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.
- You have the right and responsibility to take part in all the choices about your unborn child's health care.
- You have the right to speak for your unborn child in all treatment choices.
- You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
- You have the right to talk to you 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.
- 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, inform you if they think your doctor or the health plan was right.
- 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.

- You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
- You must become involved in the doctor's decisions about your unborn child's care.
- If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
- You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Handbook to understand how the rules work.
- 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.
- You must report misuse of CHIP Perinatal services by health care providers, other Members, or health plans
- Talk to your provider about all of your medications.

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 PCHP. Please refer to the "Section VIII – Claims" for detailed billing information.

PCHP will include payment for postpartum visits to the delivering provider when the delivery is billed with the delivery/ postpartum CPT code of 59409 for vaginal deliveries, and 59514 for Cesarean deliveries.

PCHP Postpartum care provided must be billed using procedure code 59430. PCHP policy allows a maximum of one (2) postpartum visit per pregnancy within 60 days of delivery. PCHP providers should conduct a postpartum visit between the 21st and 56th day after delivery in accordance with HEDIS® standards.

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 PCHP for these services will be denied as not a covered benefit.
- Claims for Perinate Mothers between 186-200% FPL will be submitted to PCHP 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, PCHP 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.

General Eligibility for CHIP

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.

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

Reference Material Forms

Below you will find links or copies of these forms:

- Texas Authorization/Referral Form and Instructions
- Sterilization Consent Form – English
- Sterilization Consent Form – Spanish
- Private Pay Agreement Form
- Example of Medicaid State ID card
- Example of PCHP CHIP and CHIP Perinate Member ID card
- Example of PCHP STAR Member ID Card
- Provider Appeal Request Process and Form
- Provider Dispute Request Process and Form
- Member/Provider Complaint Form(s)
    - HEALTH*first* members
    - KIDS*first* members
    - Providers
- Application for Vaccines for Children Program
- Texas Medicaid and CHIP Reference Guide
- STAR Value Added Services
- CHIP Perinate Value Added Services
- Uniform Managed Care