WELCOME TO THE NETWORK:
PROVIDER ONBOARDING & ORIENTATION

Parkland
Community Health Plan

PARKLAND COMMUNITY HEALTH PLAN (PCHP) INTRODUCTION

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ABOUT PCHP

OUR HISTORY

PCHP is a locally owned and operated Managed Care Organization (MCO), founded by Parkland Health, that has served Medicaid and CHIP members in North Texas since 1999.

OUR PROGRAMS

PCHP coordinates services for STAR and CHIP members in the Dallas Service Area.

STAR (Previously **Parkland HEALTH*first***)

- No-cost coverage for income-eligible children, pregnant women, and families.

TEXAS STAR
Your Health Plan ★ Your Choice

CHIP/CHIP PERINATE. (Previously **Parkland KIDS*first***)

- Low-cost coverage for children (0–18) whose families earn too much for Medicaid but not enough for private insurance.
- Includes **CHIP Perinate, CHIP Perinate Newborn**

CHIP

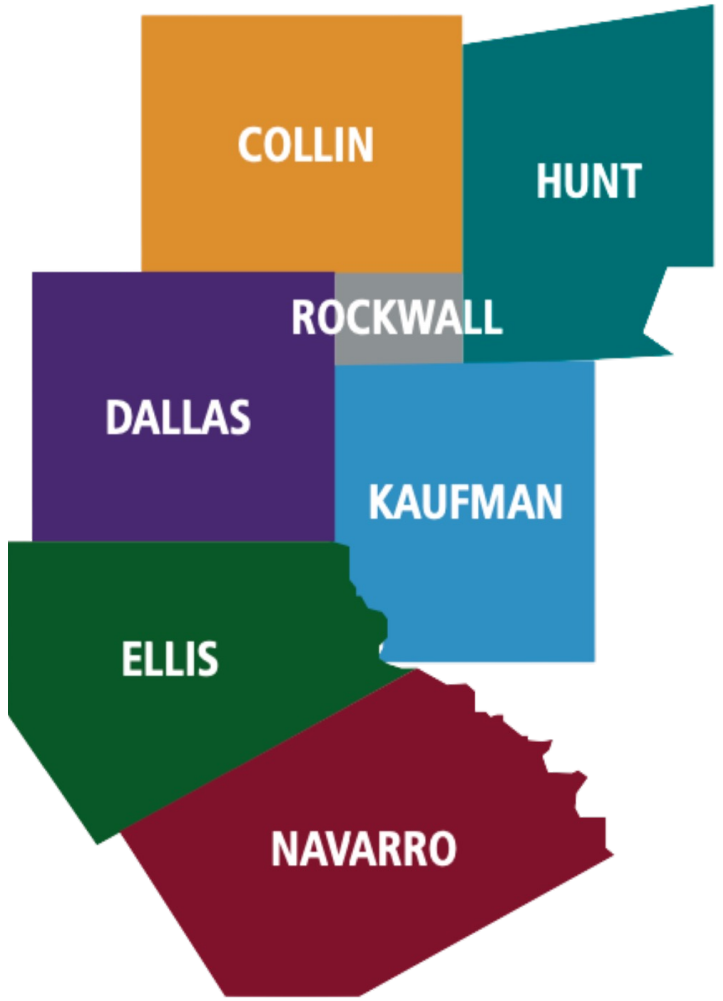
PCHP DALLAS SERVICE AREA

160,000+ Members

9,000+ Providers

40+ Hospitals & Urgent Care Centers

Across 7 Counties



PCHP's Service Area

TEXAS PROVIDER MARKETING GUIDELINES

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TEXAS PROVIDER MARKETING GUIDELINES

THESE GUIDELINES CLARIFY WHAT PROVIDERS CAN (AND CANNOT) DO WHEN COMMUNICATING WITH STAR AND CHIP MEMBERS.

PROVIDERS MAY:

- Inform patients which Medicaid and CHIP plans they accept.
- Describe services and benefits of MCOs with which they participate.
- Share MCO contact info if requested.
- Distribute and help complete enrollment applications.
- Direct patients to enroll through the Administrative Services Contractor (Maximus).

PROVIDERS MUST:

- Distribute materials from **all** contracted MCOs or **none at all.**
- Ensure all materials:
  - ❑ Meet HHSC content, reading level (6th grade), and size requirements.
  - ❑ Are available in English and Spanish (plus other languages upon request).
  - ❑ Include provider's name and office location.
  - ❑ Do not contain HHSC logos or misrepresent services.
  - ❑ Avoid misleading claims, financial incentives, or negative references to other providers.

The full **Texas Provider Marketing Guidelines** are available on the Texas HHSC website.

COMPLIANT & NONCOMPLIANT MARKETING ACTIVITIES*

PERMISSIBLE	PROHIBITED
Sending marketing materials to every person in a specific zip code, without specifically targeting Medicaid clients	Unsolicited personal contact such as direct mail, telephone, and door-to-door solicitation
Sending an appointment reminder to a Medicaid client	Offering gifts or other incentives designed to influence a client's choice of provider
Participating at a health education event and providing branded giveaways valued at no more than $15 each	Providing giveaways or incentives valued at more than $15 each, or passing out marketing materials
Sharing marketing materials via television, radio, newspaper, internet, or billboard ads.	Sharing marketing materials or making any other communication efforts intended to influence the client's choice of provider
Provider marketing conducted at: • Community-sponsored educational events or health fairs • Outreach activity or similar community event that does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education	Sending marketing materials to a client to offer inducements or incentives
Provider marketing for the purpose of: • Providing appointment reminders • Distributing promotional health materials • Providing information about services you offer • Coordinating care	Unsolicited personal contact at a childcare facility or any other type of facility
	Targeting clients solely because they receive Medicaid/CHIP benefits.

**The information provided is not intended to be comprehensive or to identify all applicable state and federal laws and regulations. Providers remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.*

CULTURAL COMPETENCY

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CULTURAL COMPETENCY

WHY IT MATTERS

PCHP is committed to ensuring that our staff and providers are informed of the importance of providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

PCHP RESOURCES

For more information, visit the Provider Resources Page on the PCHP website to review our **Cultural Competency presentation.**

HIPAA AND PHI COMPLIANCE

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PROTECTED HEALTH INFORMATION (PHI)

PHI INCLUDES ANY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, SUCH AS:

- Member health conditions, health care provided, or payments made.
- Member identifiers like name, SSN, medical record number, or account number.
- Physical or electronic records, biometric data, and other unique identifiers.

PRIVACY IDENTIFIERS – EXAMPLES		
Name	Email Address	Device and Biometric Identifiers
Address	Social Security Number	Medical Record Number
Phone Number	Health Plan Beneficiary's Phone Number	Full-face photograph(s)

PENALTIES FOR HIPAA VIOLATIONS:

- Fines start at $100 per violation and can escalate up to $1.5 million annually.
- Criminal sanctions may apply for wrongful disclosure or malicious acts.

For more on HIPAA privacy protections and PHI, visit the Privacy Rule Guidance page on HHS.gov.

PROTECTED HEALTH INFORMATION (PHI)

INCLUDES ANY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION RELATED TO:

- A member's past, present, or future physical or mental health conditions
- The provision of health care to a member
- Payment for past, present, or future health care services
- Identification of a member (e.g., name, ID number, address)
- Any information that can reasonably be used to identify the individual
- Protection of electronic and physical data, including system access, building access, and workspace security

PENALTIES FOR MISUSE OR WRONGFUL DISCLOSURE OF PHI:

- Civil fines start at **$100 per violation** and may total up to **$1.5 million per year** for repeated violations
- **Intentional or malicious disclosures** may lead to additional civil penalties and **criminal sanctions** against individuals or entities involved

Refer to applicable state laws and the PCHP Provider Manual for detailed PHI privacy and security requirements.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) IS A FEDERAL LAW THAT PROTECTS THE PRIVACY AND SECURITY OF INDIVIDUALS' HEALTH INFORMATION:

PRIVACY	SECURITY
Each individual's right to control how their personal health information is used or shared.	Protection of an individual's physical and electronic health data, including access to systems, buildings, and workspaces.

Providers are <u>required</u> to follow HIPAA regulations to protect member information and prevent its unauthorized use or disclosure.

ACCESS AND AVAILABILITY STANDARDS

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APPOINTMENT ACCESSIBILITY STANDARDS

TYPE OF CARE	APPOINTMENT STANDARD
Urgent Care (Urgent Specialty Care and Behavioral Health Services)	Within 24 hours
Initial Outpatient Behavioral Health Visits (does not apply to CHIP Perinate)	Within 10 business days or 14 calendar days
Initial Outpatient Behavioral Health Visits Upon Discharge From an Inpatient Psychiatric Setting	Within 7 calendar days

It is highly recommended that providers share this information with their appointment schedulers to ensure compliance with the required appointment availability standards.

PREVENTIVE CARE AND PCP STANDARDS

APPOINTMENT TYPE	STANDARD
New Covered Persons	14 days for newborns; 60 days for children and adults
Preventive Visits	14 days for newborns; 60 days for all others
CHIP/CHIP Perinate	Well-child visits per AAP guidelines
STAR Medicaid	Texas Health Steps checkups per schedule (no later than 60 days)

Appointments must be offered as soon as possible and not exceed these timeframes.

24/7 ACCESS AND OFFICE REQUIREMENTS

SERVICE	STANDARD
Referrals	Within 30 calendar days
After-Hours Access	Coverage 24/7, 365 days a year
Call Return Time	Within 30 minutes of after-hours call
In-Office Wait Time	Within 30 minutes of arrival

24/7 PHONE ACCESS REQUIREMENTS

PRIMARY CARE PROVIDERS (PCPs) MUST ENSURE 24-HOUR PHONE ACCESS USING ONE OF THE FOLLOWING METHODS:

- **Answering Service:** Calls must be answered and returned by the PCP (or designee) within **30 minutes.**
- **Multilingual Recorded Message:** Must include the PCP's or another provider's **direct number** that will be answered (not just a referral).
- **Call Transfer to On-Call Provider:** Transfers must result in the call being returned within **30 minutes.**

NOTE: Voicemail instructing patients to leave a message or go to the ER is **not allowed**, unless it's a true emergency.

CHILDREN OF MIGRANT FARM WORKERS (MFWs)

WHAT PROVIDERS NEED TO KNOW

- Children of MFWs may receive checkups early—before leaving the area—if services are due.
- These early checkups are considered **accelerated services** and should be provided whenever possible.
- A **make-up exam** for a missed visit is not an accelerated service—it is considered a **late checkup.**
- You may receive notification if a patient is identified as MFW; these children may be at higher risk for pesticide exposure or job-related injuries.
- If you identify a patient who may be an MFW, call **Provider Services** at **1-888-672-2277.**

COMPLIANCE AND NOTIFICATIONS

PROVIDERS MUST NOTIFY PROVIDER RELATIONS IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR:

- **Access Issues:** Unable to meet Access and Availability standards (i.e., temporary or permanent access disruptions)
- **Service Limitations:** Restrictions on treating members (i.e., limited-service hours, service restricted to specific settings)
- **Practice or Demographic Changes:** Changes to provider information (i.e., telephone number updates, suite changes, office relocations)

QUARTERLY SURVEY REQUIREMENTS:

- PCHP conducts a quarterly Access and Availability Survey to monitor network adequacy, as required by State Medicaid, Medicare, and proprietary client contracts.
- Providers must complete the survey at least once per quarter, even if no changes have occurred.
- Results are shared with NCQA and state health plans.
- Data supports access monitoring, network development, and contracting decisions.

Contact the PCHP Provider Relations Team at PCHP.ProviderRelations@phhs.org

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

PCHP'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM ENSURES HIGH STANDARDS IN CLINICAL CARE AND SERVICE DELIVERY ACROSS ALL AREAS OF OUR HEALTHCARE SYSTEM.

PROGRAM HIGHLIGHTS:

- **Member-Centered**: Tailored to age groups, risk status, and disease categories.
- **Compliant**: Meets all state and federal Quality Improvement (QI) requirements.
- **Collaborative**: Guided by a multidisciplinary committee with diverse expertise.

ACCESS TO CARE AND COVERED SERVICES

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GENERAL PROGRAM OVERVIEW

PRIMARY CARE AND COORDINATION

- **PCP selection is required.** If a member doesn't choose one, they're automatically assigned an in-network PCP. They can change their PCP at any time.
- **Most specialty care is coordinated through the member's PCP and typically requires a referral.** PCPs are expected to coordinate care before referring to a specialist.
- There are **two key exceptions** where members may **contact in-network providers directly, without a referral: Behavioral Health Services & THSteps Providers/Covered Services.**

COPAYMENTS

- **STAR Medicaid**: No copays
- **CHIP:** Copays based on federal poverty line (FPL)
- **CHIP Perinate & Newborn:** No copays

COVERED SERVICES AND ACCESS REQUIREMENTS

THE FOLLOWING SERVICES ARE COVERED FOR MEMBERS, BUT MUST FOLLOW NETWORK AND PRIOR AUTHORIZATION GUIDELINES:

- **Lab and radiology services** – should be performed at contracted/in-network facilities. If out-of-network services are needed, providers must submit a justification to avoid delays or potential adverse determinations.
- **Prescription drugs** – must be on the formulary and filled at a network pharmacy.
- **Inpatient hospitalizations and select outpatient services** – require prior authorization.

DIRECT ACCESS IS AVAILABLE FOR THE FOLLOWING SERVICES:

- **Ob/Gyn care**
- **Vision services** – coordinated through Avēsis Vision
- **Therapeutic optometry** – in-network providers only (excludes surgery)
- **Behavioral health services** – coordinated by PCHP
- **Texas Health Steps exams***
- **Family planning services***

**STAR Medicaid benefit only*

EARLY CHILDHOOD INTERVENTION (ECI)

OVERVIEW

The ECI program offers in-home or community-based services for children (ages 0–3) with suspected developmental delays or disabilities. Services may include:

- Screenings
- Physical, occupational, speech, and language therapy
- Other tools to support effective learning

ECI REFERAL PROCESS & REQUIREMENTS

- Providers must refer any child under age 3 to the Texas HHS ECI program **within 7 days of identifying a disability or suspected delay**.
- A medical diagnosis is **not required** for a referral
- To refer families for services, providers may contact the local ECI program, or the **HHS Office of the Ombudsman at 1-877-787-8999 (TTY: 7-1-1); select language and then Option 3.**
- Click **here** for more information about the ECI program and requirements.

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT)

ELIGIBILTY & PROGRAM OVERVIEW

- PCHP covers NEMT services for STAR Medicaid members, which are scheduled and managed by our partner, **Access2Care (A2C).**
- **NEMT is available for Medicaid covered healthcare services only—it does not include ambulance transport or trips for non-medical needs.**
- Transportation services may include, but are not limited to:
    - Rides to appointments via bus, taxi, van, Lyft/Uber, or airfare
    - Passes or tickets for public transportation
    - Gas cards or direct fuel reimbursement
    - Tickets or passes for public transportation
    - Curb-to-curb or wheelchair-accessible vans
    - Mileage reimbursement for an Individual Transportation Participant (ITP)
    - Meals and lodging for members under 21 who must travel long distances
- Members and providers can arrange transportation directly through A2C.
- A2C may contact provider offices to confirm appointments—please assist with validation when contacted.
- **For help, members and providers can call A2C at 1-833-931-3844.**

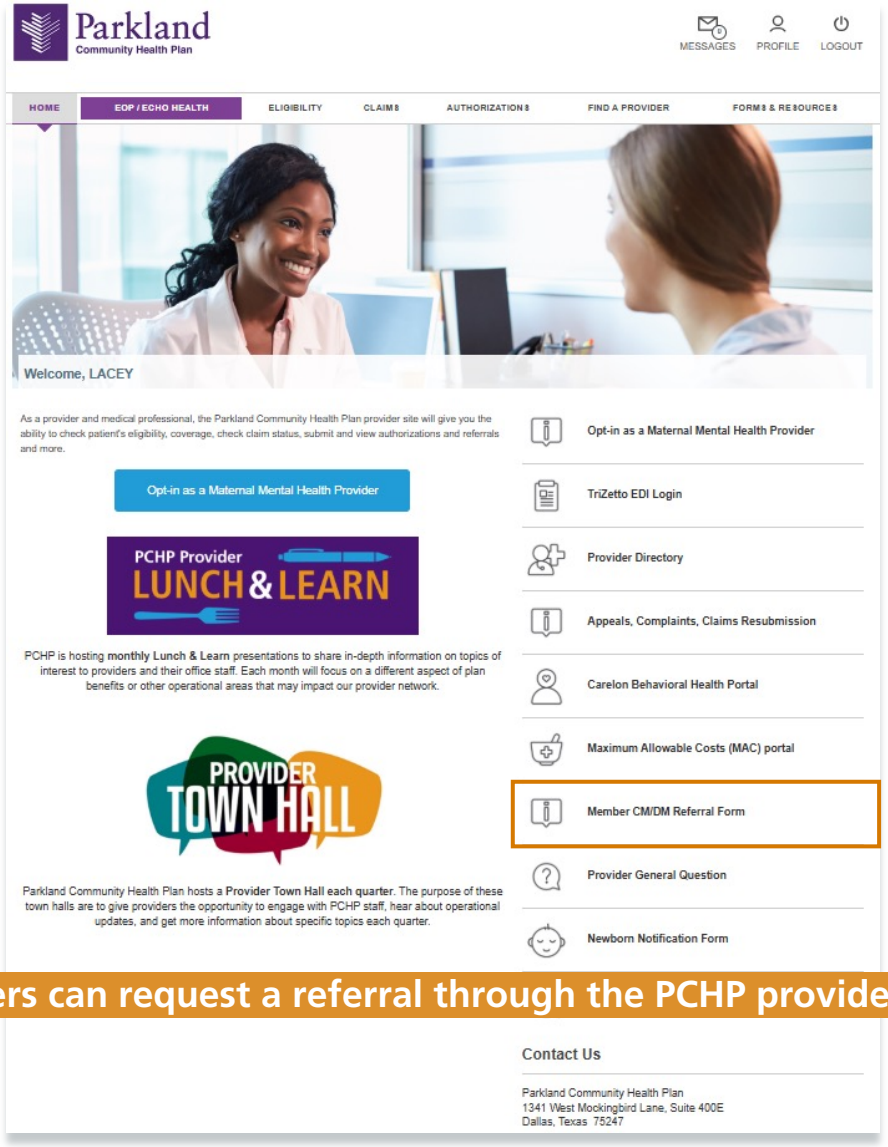
REFERRALS

IN-NETWORK REFERRALS

PCPs can refer a member to an in-network specialist for consultation and treatment **without** submitting a prior authorization request to PCHP.

OUT-OF-NETWORK REFERRALS

If the PCP believes a member should be referred to an out-of-network provider, including medical partners not contracted with PCHP, they **must submit documentation demonstrating the need for review and prior authorization before the referral can occur.** The PCP and specialist must document coordination of all referrals and services provided.



Providers can request a referral through the PCHP provider portal.

COVERED SERVICES WITH LIMITATIONS

CERTAIN STAR MEDICAID BENEFITS HAVE COST OR SERVICE LIMITS

Examples include:

- **Home health, DME, and medical supplies** (e.g., diabetic supplies, glucose strips)
- **Therapies**: Occupational, speech, and physical therapy
- **Psychological and neuropsychological testing**
- **Mental/behavioral health services**: Includes individual and group therapy

For complete benefit and limitation details, refer to the **Texas Medicaid Provider Procedures Manual.**

DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES

STAR MEDICAID MEMBERS ARE ELIGIBLE TO OBTAIN DME/MEDICAL SUPPLIES WHEN ORDERED BY AN IN-NETWORK PROVIDER.

REQUIREMENTS FOR EQUIPMENT/SUPPLIES

- **Under $5,000** → Providers must complete the appropriate DME/Medical Supplies Physician Order Form.
- **Over $5,000** → Prior Authorization is **required**.

IMPORTANT NOTE: Certain DME codes require Prior Authorization **regardless of cost**. Providers should confirm requirements using the PCHP **Prior Authorization Lookup Tool** or **List**.

STATE-ADMINISTERED PROGRAMS & NON-CAPITATED SERVICES

✪ STAR Medicaid Members Only

Texas HHSC and Partners	✪	THSteps Dental (including Orthodontia)
	✪	THSteps Environmental Lead Investigation (ELI)
	✪	THSteps Personal Care Services (PCS) – for members ages 0-20
		Early Childhood Intervention (ECI) Service Coordination & Specialized Skills Training
	✪	HHSC Hospice Services
	✪	HHSC-contracted providers of service coordination for individuals with intellectual or developmental disabilities
	✪	School Health and Related Services (SHARS)
Department of State Health Services (DSHS)		Tuberculosis Services Provided by DSHS Approved Providers (Directly Observed Therapy and Contact Investigation)
Other State Agencies		Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
***Special Circumstances**		Inpatient Facility Charges: For certain inpatient stays under STAR, facility charges are paid through Fee-for-Service or the prior MCO as defined in the Span of Coverage policy.
		Mental Health Targeted Case Management and Rehabilitative Services: Available for Dual Eligible Members (members eligible for both Medicaid and Medicare) through Non-Capitated Services.

NOTE: *The remaining programs may serve STAR Medicaid members, but they are not exclusive to them. Eligibility criteria vary by service and agency.*

OB/GYN SERVICES

KEY INFORMATION FOR PROVIDERS:

- Female members can access in-network Ob/Gyns directly.
- For any out-of-network services, prior authorization must be requested. Resources are located on our website at **Providers.ParklandHealthPlan.com/Prior-Authorization**. Providers may also contact our provider services line for more information.
- Pregnant members past 24 weeks gestation may continue seeing their current Ob/Gyn—even if out-of-network—through their postpartum visit, as long as:
    - The current provider agrees to continue care,
    - The member chooses not to switch to an in-network provider, and
    - Prior authorization has been approved.

DENTAL COVERAGE & PROVIDER CONTRACTS

OVERVIEW

Dental Maintenance Organizations (DMOs) provide routine dental services to eligible STAR Medicaid and CHIP members.

Members are assigned to **one of three statewide dental plans:**

	DentaQuest	MCNA Dental Plans	UnitedHealthcare Dental
STAR Medicaid	1-800-516-0165	1-855-691-6262	1-800-822-5353
CHIP/CHIP Perinate	1-800-508-6775		

PROVIDER RESOURCES

To obtain a list of participating dental providers, members may contact:

- **Texas Health Steps**: **1-877-THSTEPS (Toll-free: 1-877-847-8377)**
- **PCHP Provider Services: 1-888-672-2277**

VISION SERVICES

VISION SERVICES ARE MANAGED BY AVESIS

- Members may access routine vision services, **without a referral from their PCP**, provided they are coordinated through Avēsis.
- PCPs can refer directly to a participating ophthalmologist for non-routine vision services.
- In-network ophthalmologists and optometrists may perform non-surgical services within the scope of their licenses without a referral from the member's PCP or an authorization from PCHP.

CONTACT INFORMATION

Visit the **Avesis website** or call **1-866-678-7113** for more information or assistance.

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)

PROGRAM OVERVIEW

The TVFC program helps ensure that children who are uninsured or underinsured receive all recommended vaccines to protect against preventable diseases.

KEY BENEFITS FOR PROVIDERS

- Expands vaccine access for at-risk children.
- Removes financial barriers to immunization.
- Allows children to receive vaccines through their PCP or designated "medical home."

ENROLLMENT INFORMATION

- Participation is simple and encouraged. Learn more or apply on the **Immunizations Enrollment Page** of the Texas DSHS website.

BEHAVIORAL HEALTH (BH) SERVICES AND SERVICE COORDINATION

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BEHAVIORAL HEALTH (BH) SERVICES

DIRECT ACCESS

- Members can use behavioral health (BH) services **without a referral** from their PCP.

ROLE OF THE PCP

- **Screen, assess, treat, or refer** members for behavioral health needs, as appropriate.
- **Provide care** for mental health and/or substance use concerns within their scope of practice.
- **Guide members** on how and where to obtain behavioral health support.

BEHAVIORAL HEALTH (BH) SERVICES OVERVIEW

KEY PROGRAMS AND SERVICES

- **SBIRT (Screening, Brief Intervention, and Referral to Treatment):** A preventive service that identifies members at risk for substance use and connects them to appropriate support. Available to individuals age 10 and older. No prior authorization is required.
- **Opioid Use Disorders (OUD) & Medication-Assisted Treatment (MAT):** Combines medication and therapy to treat alcohol and OUDs. Both methadone and non-methadone options are available and covered without prior authorization.
- **Attention-Deficit/Hyperactivity Disorder (ADHD) Services:** Includes evaluation, counseling, and medication management for children and adolescents. PCPs may diagnose and treat ADHD or refer to a specialist.
    - A follow-up visit is required within 30 days of starting ADHD medication.
    - At least two additional follow-up visits should occur within the following 270 days.
    - Services may be reimbursed when clinically appropriate and documented per TMPPM guidelines.

SUPPORTING BH SERVICES: ROLE OF THE PCP

KEY RESPONSIBILITIES FOR SCREENING, COORDINATION, AND REFERRAL

- PCPs may provide behavioral health services within the scope of their practice. Primary Care Providers are responsible **for coordinating the member's physical and behavioral health care,** including facilitating **referrals to behavioral health providers** when necessary. PCPs should **submit claims to PCHP** for consideration.
- PCPs are responsible for **identifying and referring members** age 3 and older who are suspected of having a **developmental delay, developmental disability, Severe Emotional Disturbance (SED), mental illness,** or **substance use disorder (SUD).**
- PCPs must use **validated screening and assessment tools** to evaluate behavioral health needs and refer children for **specialized evaluations** when appropriate.
    - Validated behavioral health screenings tools are available on the **PCHP website.**

SCREENING TOOLS AND TECHNIQUES

PROVIDERS ARE ENCOURAGED TO SCREEN FOR BOTH MENTAL HEALTH AND SUBSTANCE USE DISORDERS USING VALIDATED SCREENING TOOLS INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

- PHQ-2, PHQ-9, PHQ A
- GAD-7
- Patient Stress Questionnaire
- MDQ
- C-SSRS
- ADHD Rating Scale-IV
- NICHQ Vanderbilt Assessment Scales
- M-CHART-R
- SCOFF
- PC-PTSD
- PSSI (PTSD Symptom Scale Interview)
- PCL-C (PTSD Checklist – Civilian Version)
- AUDIT-PC
- CAGE-AID
- CRAFFT
- NIDA
- Screening for Obsessive-Compulsive Disorder

NOTE: This is not a comprehensive list. These screening tools may be used by a variety of licensed health care providers.

COORDINATION OF CARE BETWEEN PH & BH PROVIDERS

PROVIDER REQUIREMENTS

- **All BH and PH providers** (including PCPs, OB/GYNs, internists, and other relevant provider types) must **share clinical information** with each other regarding members with co-occurring physical and behavioral health conditions, in accordance with federal and state law.
    - A fillable **Coordination of Care Form** is available to support this documentation.
- PCPs will receive **initial and quarterly summary reports**—or more frequently if clinically indicated— on the member's behavioral health status from behavioral health providers.

TO SUPPORT OUR BH AND PH NETWORK, PCHP IS COMMITTED TO KEEPING PROVIDERS CURRENT ON COORDINATION OF CARE PRINCIPLES AND QUALITY INITIATIVES. THIS INCLUDES, BUT IS NOT LIMITED TO, PROVIDING EDUCATION AND TRAINING ON:

- **Strategies** that promote high-quality, whole-person care and help prevent gaps in treatment.
- **Practice-relevant tools** that support integrated or coordinated care delivery.
- **Validated** behavioral health (BH) **screening tools**.
- **New models** of behavioral health interventions.

SERVICE COORDINATION AND INTERVENTIONS

SERVICE COORDINATION HELPS ADDRESS THE INDIVIDUAL NEEDS OF MEMBERS WITH PHYSICAL HEALTH AND/OR BEHAVIORAL HEALTH RISKS BY FACILITATING APPROPRIATE, HIGH-QUALITY CARE.

- PCHP's Service Coordination program is part of a comprehensive healthcare management model, offering a continuum of services including service coordination and disease management.
- The program works to reduce barriers by identifying unmet needs and helping members access appropriate resources. This may include:
    - Care coordination
    - Community resource connection
    - Disease-specific education
    - Interventions that support safe, independent living
- Service Coordinators provide initial and ongoing assistance with identifying, selecting, and using covered services and supports to improve well-being and community integration.

SERVICE COORDINATION AND INTERVENTIONS

MEMBER ELIGIBILITY FOR SERVICE COORDINATION

All PCHP members are eligible to enroll in the Service Coordination program. Targeted outreach is conducted for members classified as **high-risk** or identified as having **Special Health Care Needs (MSHCN).** Participation is voluntary and requires member consent.

- **Members considered high-risk or having special health care needs may include:**
  - Members receiving Early Childhood Intervention (ECI) services
  - High-risk pregnant women or those with a history of pre-term birth
  - Members with high-cost catastrophic conditions or high service utilization
  - Members with mental illness and co-occurring substance use disorder
  - Members with behavioral health conditions that may impact physical health or treatment compliance, including those with serious emotional disturbance or serious and persistent mental illness
  - Members with serious ongoing illness or a chronic complex condition expected to last long-term and requiring continuous therapeutic or pharmacologic care (e.g., HIV/AIDS, respiratory illness, diabetes, heart disease, kidney disease), or those receiving in-home/facility-based therapy or attendant care

SERVICE COORDINATION AND INTERVENTIONS

SERVICE COORDINATION INTERVENTIONS MAY INCLUDE:

- Comprehensive assessments and individualized, integrated care planning with member-centered goals.
- Assistance accessing physical and behavioral health services, benefits, and community resources.
- Linkages to peer support services.
- Appointment scheduling and transportation assistance.
- Health education to promote self-management and adherence to care.
- Coordination among behavioral health providers, PCPs, health homes, and medical specialists.
- Support during transitions of care to ensure continuity and safety.
- Motivational interviewing to encourage engagement and behavior change.
- Provision of condition-specific self-management tools and coaching.
- Identification of and support addressing non-medical determinant of health needs.

SERVICE COORDINATION AND INTERVENTIONS

HOURS OF OPERATION

Our Service Coordination team of licensed nurses and social workers are available:

Monday – Friday | 8 am – 5 pm (Central Time)

Confidential voicemail is available 24/7.

SERVICE COORDINATION REFERRALS

To refer a member to the Service Coordination team, please provide:

- Member demographics (name, Medicaid ID, authorized representative name and contact info, if applicable)
- Brief reason for referral
- Any identified needs or requested resources

To make a referral, call 214-393-7003 or email PCHPUMCaseManagement@phhs.org.

VALUE-ADDED SERVICES AND MEMBER BENEFITS

Parkland
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EXTRA BENEFITS FOR PCHP MEMBERS

VALUE-ADDED SERVICES (VAS) OVERVIEW

These services are available at low or no cost, depending on the member's plan. Examples include:

24/7 live nurse line

Support for pregnant and postpartum members, such as:

- Car seats
- Play yards*
- Home-delivered meals

Allowance for eyeglass frames

Additional transportation assistance*

Sports physical

Allowance for dental services*

Members can learn more about these added benefits through the PCHP Benefits & Services webpage, which they can access at **ParklandHealthPlan.com/Members/Benefits.**

**STAR Medicaid benefit only*

EXTRA BENEFITS FOR PCHP MEMBERS

HEALTH INCENTIVES PROGRAM – PAID REWARDS

In addition to VAS, members can earn rewards for completing health-focused activities that support physical and behavioral health.

EXAMPLES OF ELIGIBLE ACTIVITES:

- Complete a Health Risk Assessment (HRA)
- Complete your Prenatal Visit Series
- Complete an A1c blood test every 6 months*
- Complete timely well-child & adolescent checkups
- Receive your annual flu vaccine
- And more!

The full list of eligible activities is available at **ParklandHealthPlan.com/PaidRewards**

HOW THE PROGRAM WORKS

- Members, or their parents or guardians, can create an account to track earned points and redeem rewards.
- Rewards can be redeemed online or by phone through the **Parkland Rewards Program**.

MemberWell.com/PCHPRewards | **1-855-651-5093 (TTY: 1-844-488-9731)**

INTERPRETER AND TRANSLATION SERVICES

OVERVIEW

Interpreter services are available to meet the needs of our members. If a provider does not have access to a translator prior to a member's appointment, PCHP will coordinate interpreter services—**including sign language and in-person or phone-based interpretation.**

INTERPRETER AVAILABILITY & SCHEDULING

- **All interpreter services** require **4–5 business days** advance notice
- Requests submitted with fewer than 3 days' notice may not be guaranteed
- Interpreter cancellations must be reported to PCHP as soon as possible after the member cancels or reschedules

IMPORTANT: If an interpreter is NOT canceled within 24 hours of the scheduled appointment, the health plan is still charged for the service.

NEED TO REQUEST AN INTERPRETER FOR A FUTURE APPOINTMENT?

- **Call Provider Services** at **1-888-672-2277** → be sure to provide the appointment date and time.
- Email requests securely at **PCHPMemberAdvocate@phhs.org**

MEMBER ELIGIBILITY

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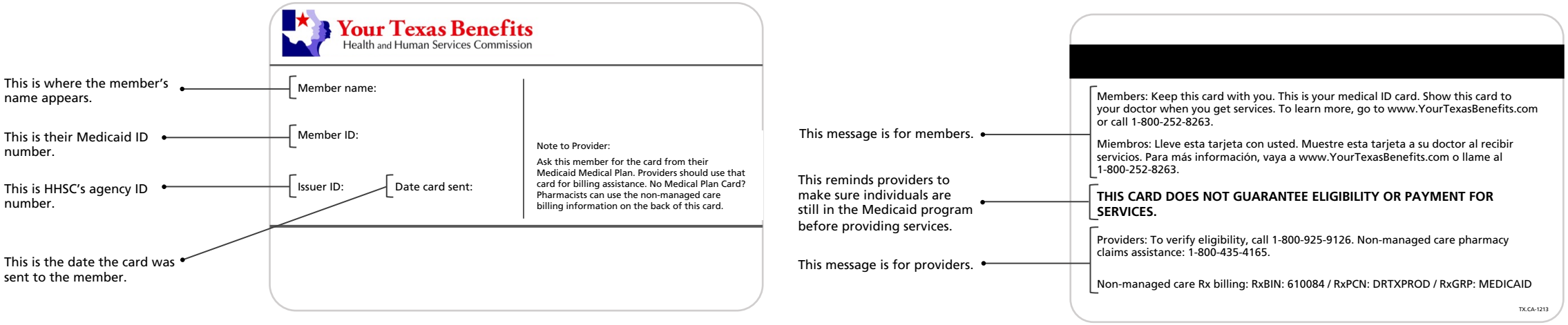
YOUR TEXAS BENEFITS (YTB) STAR MEDICAID CARD

The **YTB Medicaid card replaces the STAR Medicaid ID letter** (Form 3087) members previously received by mail.



Texas HHSC now uses digital tools, including an online portal, to verify STAR Medicaid eligibility and provide real-time access to a patient's service and treatment history.

PCHP MEMBER ID CARDS

STAR MEDICAID

Parkland Community Health Plan **Plan Type:** STAR

TEXAS STAR Your Health Plan • Your Choice | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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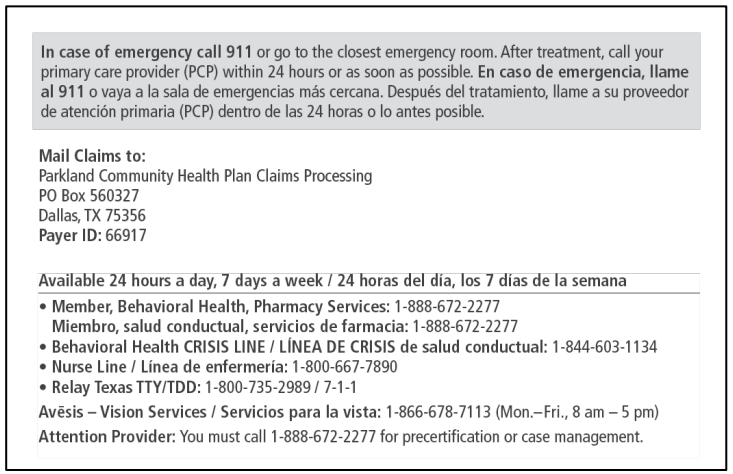


In case of emergency call 911 or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su proveedor de atención primaria (PCP) dentro de las 24 horas o lo antes posible.

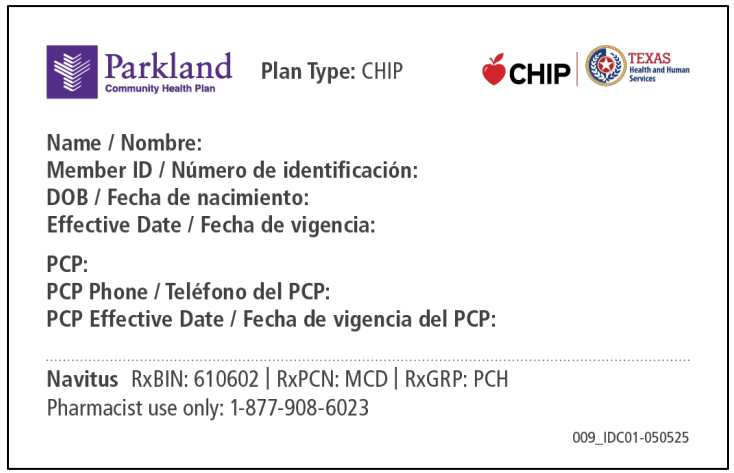
Mail Claims to:
Parkland Community Health Plan Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

- **Member, Behavioral Health, Pharmacy Services:** 1-888-672-2277
  Miembro, salud conductual, servicios de farmacia: 1-888-672-2277
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-667-7890
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vista: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP



Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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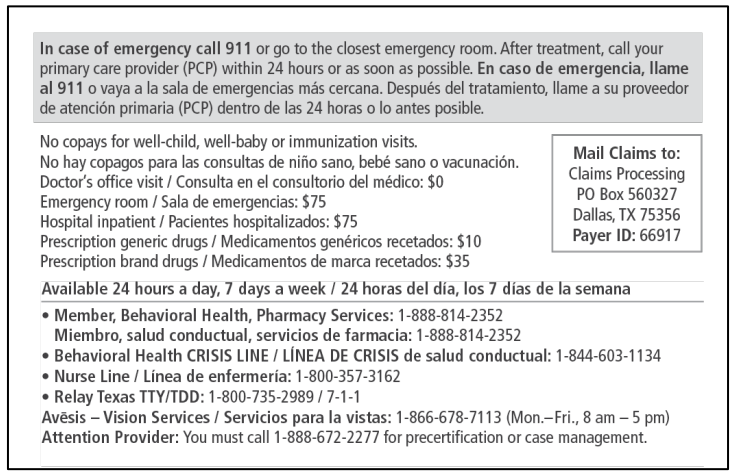

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No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
Prescription generic drugs / Medicamentos genéricos recetados: $10
Prescription brand drugs / Medicamentos de marca recetados: $35

Mail Claims to:
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

- **Member, Behavioral Health, Pharmacy Services:** 1-888-814-2352
  Miembro, salud conductual, servicios de farmacia: 1-888-814-2352
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-357-3162
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vistas: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

PCHP MEMBER ID CARDS

CHIP PERINATE – Below 198% FPL

Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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No copays for covered benefits.
No hay copagos para los beneficios cubiertos.

CHIP Perinate is a service under the Children's Health Insurance Program.
CHIP Perinate es un servicio del Programa de Seguro Médico para Niños.

Hospital Facility Billing:
TMHP-Attn: Claim Administrator
12365-A Riata Trace Pkwy
Austin, TX 78727

Professional/Other Services Billing:
Parkland Community Health Plan Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP PERINATE – Above 198% FPL

Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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No hay copagos para los beneficios cubiertos.

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Mail Claims to:
Parkland Community Health Plan
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP PERINATE NEWBORN

Parkland Community Health Plan **Plan Type:** CHIP Perinate Newborn

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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In case of emergency call 911 or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su proveedor de atención primaria (PCP) dentro de las 24 horas o lo antes posible.

No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
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VERIFYING MEMBER ELIGIBILITY

PROVIDERS SHOULD VERIFY MEMBER ELIGIBILITY *BEFORE* SERVICES ARE RENDERED BECAUSE:

1. **Member eligibility can change at any time**, even if the member presents a valid Medicaid ID card. The card alone does not guarantee active coverage.

2. **Failure to verify eligibility may result in claim denials or non-payment** — services rendered to ineligible members are not reimbursable.

3. **Verifying eligibility ensures:**
   - The member is **actively enrolled with PCHP** on the date of service.
   - The correct MCO is billed.
   - Prior authorization or benefit limits are confirmed in advance.

BEST PRACTICE	ALWAYS VERIFY ELIGIBILITY BEFORE EACH APPOINTMENT AND KEEP DOCUMENTATION (e.g., FORM H1027) IN CASE IT'S NEEDED FOR APPEALS.

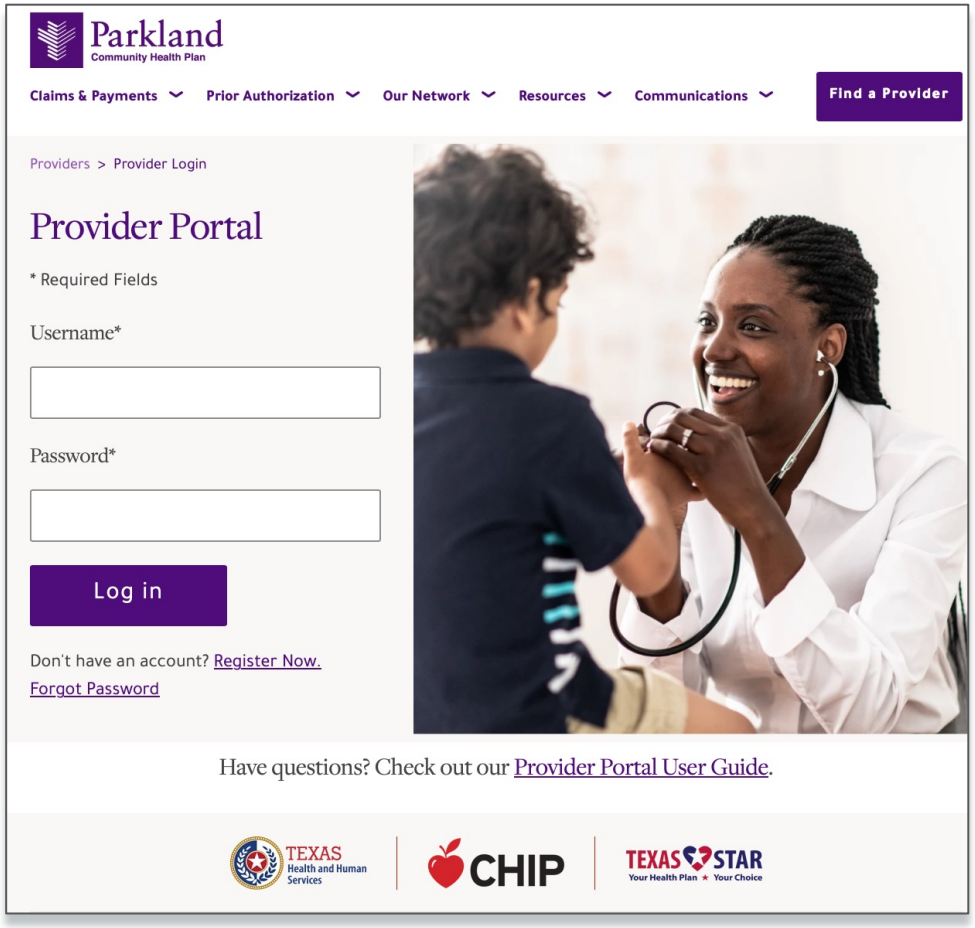
HOW TO VERIFY A MEMBER'S ELIGIBILITY

PROVIDERS CAN VERIFY A MEMBER'S ELIGIBILITY USING ONE OF THE FOLLOWING METHODS:

1. Log into the **PCHP Provider Portal.**

2. Call **Provider Services:** 1-888-672-2277
   - **Select** your **preferred language**
   - **Press 2** for Providers
   - **Press 7** to speak with a representative

3. Use **TexMedConnect** on the **TMHP website.**



MEMBER RIGHTS AND RESPONSIBILITIES

Parkland
Community Health Plan

MEMBER RIGHTS & PROTECTIONS

STAR MEDICAID AND CHIP MEMBERS HAVE THE RIGHT TO:

- Be treated with respect and dignity.
- Have their personal information protected, in accordance with U.S. law and PCHP policies.
- Receive information that is easy to understand, in a language they know.
- Understand how their health benefits work.
- Know about PCHP services, provider networks, and company information.
- Know their rights and responsibilities as a member.
- Provide feedback about what they believe their rights and responsibilities should be.
- Access care when needed.
- Discuss treatment options with their provider, regardless of cost or coverage.
- Participate in treatment decisions with their provider.
- Refuse treatment, as permitted by law.
- Access care without fear of unnecessary restraint or seclusion.
- Appoint someone to make medical decisions if they are unable.
- Have a representative speak on their behalf.
- Review and request corrections to their medical record, as allowed by law.
- Understand their billing and charges.
- Request reasonable accommodations for disabilities, as required by law.
- Request a second medical opinion.
- File complaints and appeals regarding their care.
- Be treated fairly—even after filing complaints or appeals.
- ***STAR Medicaid Only:*** Access NEMT services for rides to covered health care appointments when other transportation is not available.

ENSURING MEMBER RIGHTS: YOUR ROLE AS A PROVIDER

PROVIDER REQUIREMENTS FOR MEMBER RIGHTS COMPLIANCE:

1. **Be Familiar**—Understand the Member Rights and Responsibilities and be prepared to support members in exercising them.

2. **Post Notices**—Display a statement of Member Rights and Responsibilities prominently within your facility, in the primary language of the member population. ***Compliance with posting requirements is reviewed during site visits.***

3. **Inform Members**—Explain Member Rights and Responsibilities verbally and in writing at the start of treatment, in the member's primary language. ***Documentation of this discussion is required in the member's medical record and reviewed during chart audits.***

PHYSICAL HEALTH (PH) COORDINATION OF CARE

Parkland
Community Health Plan

TEXAS HEALTH STEPS (THSteps)

PROGRAM OVERVIEW

- Also known as the **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.**
- Available to **Medicaid members** from **birth through age 21**.
- Self-referral allowed—members may see any THSteps provider.
- Covered services include:
    - Routine physical exams
    - Dental checkups
    - Hearing and vision screenings
    - Immunizations and lab work
    - Case management

To become a THSteps provider, click on **Provider Enrollment** at **www.tmhp.com** and complete the THSteps enrollment application.

CHECKUPS & DOCUMENTATION REQUIREMENTS

WHAT COUNTS AS A *COMPLETE* CHECKUP?

- Providers must document all required components as outlined in the **Texas Medicaid Provider Procedures Manual (TMPPM)..**
- Incomplete checkups may not be reimbursed.
- Charts are subject to quality and claims review.

BILLING GUIDELINES

- Only complete medical checkups are eligible for reimbursement.
- All components must be documented and billed according to state standards.
- Refer to the TMPPM for the correct billing codes.

THSTEPS IMMUNIZATIONS

SCHEDULE GUIDELINES

- **STAR Medicaid (age 0–20):** Follow **THSteps periodicity schedule** & ACIP immunization schedule
- **CHIP/CHIP Perinate (age 0–18):** Follow ACIP immunization schedule
- Vaccines provided at no cost to enrolled providers

PROVIDER RESPONSIBILITIES

- **Document immunizations** in the Member's medical record (required for reimbursement)
- Educate families and **obtain parental consent for ImmTrac2** (Texas Health & Safety Code, Ch. 161)

RESOURCES & REPORTING

- Report vaccines to **ImmTrac2** by calling **1-800-348-9158 or through the DSHS website.**
- **Access Additional Resources:** **1-877-THSteps (Toll-free: 1-877-847-8377)**

  www.ImmunizeTexas.org

ORAL EVALUATION AND FLUORIDE VARNISH

AVAILABLE TO MEDICAID MEMBERS THROUGH CERTIFIED THSTEPS PROVIDERS

- Certified THSteps providers can bill for oral evaluation and fluoride varnish.
- Must be performed on the same day as a THSteps medical checkup.
- Certification is **required**—details available **here**.
- Follow billing and documentation guidelines in the TMPPM.

PROVIDER OUTREACH REFERRAL SERVICE

SERVICE OVERVIEW

The **THSteps Provider Outreach Referral Service** allows providers to request outreach support on behalf of a THSteps patient.

PROVIDERS USE THIS SERVICE WHEN A PATIENT HAS:

- Missed or needs to schedule a follow-up appointment
- Needs help arranging transportation
- Other barriers preventing appointment completion

To request support, providers submit the **THSteps Provider Outreach Referral Form** to the **Special Services Unit (SSU)**—the team responsible for processing and responding to these referrals.

PROVIDER OUTREACH REFERRAL SERVICE

NEXT STEPS

Once the THSteps SSU receives the referral form, they will attempt to contact the patient and provide outreach support, which may include:

- Scheduling or rescheduling appointments
- Coordinating transportation
- Educating families on the importance of preventive care
- Helping resolve barriers to keeping appointments

FORM SUBMISSIONS & ADDITIONAL SUPPORT

Fax completed referral form to the **THSteps SSU at 512-533-3867**

- For assistance, contact the PCHP Provider Relations team at **PCHP.ProviderRelations@phhs.org**

THE FREW SETTLEMENT: THSTEPS PROVIDER RESPONSIBILITIES

BACKGROUND

Frew vs. Smith (1993): Lawsuit filed on behalf of children in Texas Medicaid, citing lack of access to healthcare services.

SETTLEMENT OUTCOMES

1. Increased reimbursement rates for pediatricians and subspecialists.
2. Investments to strengthen medical care for children in rural and urban underserved areas.
3. Improved call centers to support patient understanding of treatment options.

WHAT THIS MEANS FOR THSTEPS PROVIDERS

- Provide complete THSteps checkups **within 90 days of enrollment** and **within 60 days of the child's birthday.**
- Follow THSteps periodicity schedule (medical & dental)
- Educate families on preventive health benefits
- Document THSteps checkups or note refusal of services
- Offer accelerated THSteps checkups for migrant children
- Inform pharmacists (per plan direction) of THSteps coverage
- Cooperate with compliance audits and state-led medical record reviews

CLINICAL AND UTILIZATION REVIEW PROCEDURES

Parkland
Community Health Plan

PRIOR AUTHORIZATION (PA) REVIEW PROCESS

PRIOR & CONCURRENT PA PROCESS

Participating provider submits Texas Universal Authorization Form or other appropriate form to request services on PA list.

PCHP receives information and reviews eligibility, benefits, and medical necessity and returns authorization to requesting provider.

Rendering provider coordinates, as necessary, with requesting provider.

SUBMIT PA REQUESTS:

- **By Phone:** 1-888-672-2277
- **Online: via** PCHP Provider Portal
- **By Fax:**

Prior Authorization Requests:
1-214-266-2085 or 1-844-303-1382 (toll-free)

Inpatient Prior Authorization Requests:
1-214-266-2084 or 1-844-303-2807 (toll-free)

- **Prior Auth Lookup Tool:** PA Lookup Tool

IMPORTANT POLICY GUIDELINES:

- If a PA request is incomplete, PCHP will notify the requesting provider **within 3 business days** of receipt (STAR Standard) or sooner for expedited request.
- A PA request is not a guarantee of payment. **Unauthorized services will not be reimbursed**
- An approved authorization does **not** necessarily include **all** services in the request.
- Providers should refer to the TMPPM for the correct Medicaid form based on the request type. Forms can be downloaded from the **TMHP website**. *(Medicaid forms only; non-Medicaid forms such as CSHCN are not accepted)*
- Providers may use the PA Lookup Tool for a quick check; however, effective date ranges must be confirmed by reviewing the Excel/PDF PA requirements list on the PCHP website.

AUTHORIZATION REQUEST TIMELINES — *PRIOR & CONCURRENT*

STANDARD REQUESTS

- Except for extenuating circumstances (e.g., retro-eligibility), providers must seek authorization for services according to the timelines below.
    - Inpatient requests must be submitted within 24 hours (1 business day) of the admit date to be considered timely.
    - All other requests must be made prior to or on the requested start date of authorization to be considered timely.
    - Requests for continued stay must be submitted on or before the first non-covered day to ensure continuity of care.
- Requests submitted outside of these timelines may be subject to adverse determination.

AUTHORIZATION REQUEST TIMELINES — *PRIOR & CONCURRENT*

ADVANCE REQUESTS

- Prior authorization or service authorization requests can be submitted up to 60 days prior to the expiration of the current authorization period.
- Requests must include sufficient clinical information to support a medical necessity determination.
    - This includes evidence that the member's condition is not expected to change between the request date and the requested service start date.

RETRO-ELIGIBILITY & DISCHARGE SCENARIOS

- For members discharged from care:
    - If the hospital stay is 0–14 days, providers may submit a request within 14 days of discharge using the standard clinical review process.
    - If the stay exceeds 14 days, or if the request is submitted more than 14 days after discharge (for a 0–14 day stay), the claim appeal process must be used for reimbursement.
- For members who are still in care when retro-eligibility is established, the clinical review process applies.

PRIOR AUTHORIZATION (PA)

STATUS OF A REQUEST

Providers can check the status of a PA request by:

Logging in to the Provider Portal

Calling Provider Services: 1-888-672-2277

REVIEW PERIODS BY PROGRAM TYPE

PROGRAM	AUTHORIZATION TYPE	TURNAROUND TIME
STAR (Medicaid)	Non-Urgent, Outpatient	Within **3 business days**
	Urgent, Outpatient	Not to exceed **72 calendar hours**
STAR (Medicaid) and CHIP	Inpatient	Within **1 business day** (not to exceed 72 calendar hours)
CHIP Approvals	Outpatient	Within **2 business days**
CHIP Adverse Determinations	Outpatient	Within **3 business days**

Approvals or denials will be communicated based on the urgency of the request.

PHARMACY – COVERAGE OVERVIEW

PHCP COVERS PRESCRIPTION MEDICATIONS FOR STAR MEDICAID & CHIP MEMBERS.

- Our pharmacy plan is administered by **Navitus Health Solutions**.
- Members **get their prescriptions at no cost (STAR Medicaid) or low co-pay (CHIP/CHIP Perinate)** when:
    - They use a **network pharmacy**
    - The drug is listed on the Texas **Medicaid Formulary**
- For questions about the formulary, preferred drug list, billing, prescription overrides, **prior authorizations**, quantity limits, or formulary exception contact **Navitus Health Solutions:**

Call 1-877-908-6023

Email ProviderRelations@navitus.com

Visit TXStarChip.Navitus.com

Visit the **PCHP website** for more information about our Pharmacy Prior Authorization Process.

PHARMACY – PA PROCESS & SUPPORT

SUBMITTING A PA REQUEST

Prescribers can request a prior authorization by calling **Navitus Customer Care between 8 am – 5 pm CST**. After hours, providers may leave a voicemail.

- **Phone:** 1-877-908-6023
- **Fax:** 920-735-5312
- **Mailing Address:**

  Navitus Health Solutions
  Attn: Prior Authorizations
  1025 West Navitus Dr.
  Appleton, WI 54913

PHARMACY CLAIM INFORMATION

- **BIN#:** 610602
- **Claim PCN:** MCD
- **STAR Claim Group:** PHS
- **CHIP Claim Group:** PHC

HELPFUL LINKS

- Clinical Edits
- Prior Authorization Forms (STAR/CHIP)
- Formularies (STAR/CHIP)
- Synagis Information

EMERGENCY PRESCRIPTION

72-HOUR EMERGENCY SUPPLY

- Pharmacies **must** provide a 72-hour emergency supply of a prescribed drug when:
  - The medication is needed without delay
  - A prior authorization (PA) is required but not immediately available
- This applies to all drugs requiring a PA, including:
  - Nonpreferred drugs on the Preferred Drug List
  - Drugs subject to clinical edits
- The emergency supply should be dispensed when a PA cannot be resolved within 24 hours for a medication on the **Vendor Drug Program (VDP) formulary** that is appropriate for the member's condition.
- The pharmacy should submit an emergency 72-hour prescription **if the prescribing provider cannot be reached or is unable to request a PA.**
- For more information, call Navitus Health Solutions at **1-877-908-6023 (72-Hour Emergency Supply Hotline).**

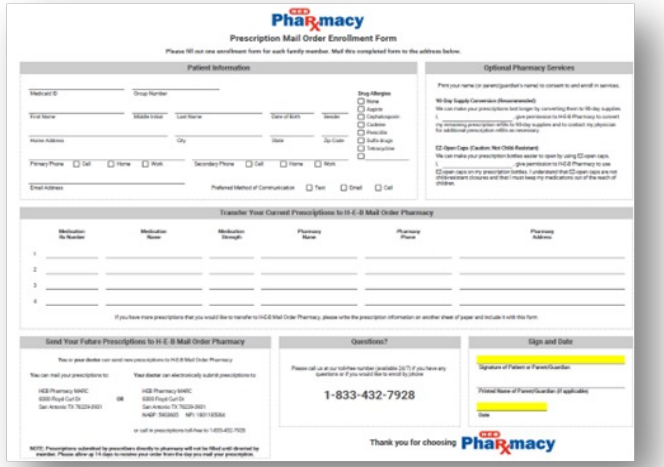
OTC MEDICATIONS & MAIL ORDER PHARMACY

OVER-THE-COUNTER (OTC) MEDICATIONS

- PCHP covers select OTC drugs **only if listed on the Texas Medicaid Formulary**.
- All OTC medications must be filled at a **network pharmacy**. Prescriptions filled elsewhere will not be covered. Check coverage **here.**

MAIL ORDER PHARMACY (OPTIONAL)

- **Preferred vendor:** H-E-B Pharmacy
- Members can choose to fill maintenance medications by mail.
- Providers may assist members in completing the **Mail Order Form.**



***Note**: Mail order is a convenient option **but not required**. Members may still fill prescriptions at any in-network pharmacy.*

TEXAS MEDICAID FORMULARY *& PREFERRED DRUG LIST (PDL)*

THE TEXAS MEDICAID FORMULARY INCLUDES:

- Brand-name and generic drugs
- Prescription and over-the-counter (OTC) medications
- Up to a 90-day supply for select maintenance drugs
- Coverage based on **National Drug Code (NDC)**
- Many preferred drugs **do not require** prior authorization.
- Check drug coverage using (internet or hand-held devices):
    - **PCHP Formulary Search**
    - **Epocrates** (Once registered, select "Texas Medicaid")
    - **Vendor Drug Program (VDP)**

ELECTRONIC VISIT VERIFICATION (EVV)

EVV IS A SYSTEM USED TO DOCUMENT AND VERIFY THAT CERTAIN MEDICAID SERVICES WERE DELIVERED AS SCHEDULED.

- It helps prevent fraud, waste, and abuse while ensuring members receive authorized care.
- PCHP follows all EVV policies and procedures established by HHSC.

WHY IS EVV REQUIRED?

The 21st Century Cures Act (Section 12006), or Cures Act, is a federal law passed in 2016 requiring states to implement EVV for Medicaid personal care services (PCS) and home health care services (HHCS) that require an in-home visit. States that do not implement EVV will receive reduced federal Medicaid funding.

PROGRAMS AND SERVICES REQUIRED TO USE EVV

Programs and services required to use EVV are defined in **HHSC Texas Administrative Code Section 354.4005, Applicability.** See the **HHSC EVV webpage** for a summary of the personal care services required to use EVV.

3100 EVV SERVICE BILL CODES

The **EVV Service Bill Codes Table** provides current billing codes for EVV-relevant services in long-term care, acute care, and managed care programs.

Program providers and FMSAs must use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations in the EVV Services Bill Codes table to prevent EVV visit transaction rejections and EVV claim match denials.

Please visit the **EVV Policies & Procedures page** on the PCHP website for more information.

EVV PROVIDER REQUIREMENTS AND COMPLIANCE

TRAINING REQUIREMENT

HHSC provides **required policy training** for all EVV providers.

VISIT MAINTENANCE UNLOCK REQUESTS (VMUR)

- An EVV **Visit Maintenance Unlock Request (VMUR)** allows a program provider, FMSA, or CDS employer to correct data elements on an EVV visit transaction after the visit maintenance time frame has expired.
- For more information, review the **HHSC EVV Visit Maintenance Policy** and submit the **VMUR Request Form.**

COMPLIANCE REVIEWS

- PCHP conducts **EVV compliance reviews** to ensure program providers, FMSAs, and CDS employers **meet EVV requirements**, including **EVV usage and Landline Phone Verification.**
- If compliance requirements are not met, PCHP will initiate contract or enforcement action. Refer to the **HHSC EVV Compliance Review Policy** for additional details.

PROVIDER DEMOGRAPHICS AND ENROLLMENT

Parkland
Community Health Plan

PROVIDER INFORMATION & CONTACT UPDATES

WHAT TO UPDATE

- Address
- Phone number
- Group affiliation
- Tax ID (via CAQH and PCHP email)
- Facility/service location changes

WHY IT MATTERS

- Accurate directories
- Reliable search functionality
- Timely communication for claims, PA, referrals
- **Submit updates at least 30 days in advance to PCHP.ContractingDepartment@phhs.org**

PROVIDER ENROLLMENT & MANAGEMENT SYSTEM (PEMS)

OVERVIEW

- **PEMS access** is tied to the provider's **NPI (National Provider Identifier)** or **API (Atypical Provider Identifier)** linked to their TMHP account. Providers must ensure their NPI or API information is current and correct.

IMPORTANT: PEMS accepts only NPIs or APIs. **Legacy identifiers (e.g., TPI)** are no longer valid for enrollment.

- Providers enrolling in Texas health care programs must enroll under one of two categories based on their NPI or API on file with **NPPES: Individual or Organization.**
- An NPI **is not required** for providers of **non-health care services**. However, they must attest that they are not healthcare providers and are **not eligible for an NPI** to receive an API. *This includes QMHPs.*
- For more information about who may not apply for an NPI, refer to **Title 45 CFR §160.103.**
- **Taxonomy codes** must be on file with NPPES to enroll and revalidate in PEMS.
- **Helpful Links:** **Enrollment Revalidation Quick Reference** | **TMHP PEMS**

FEDERAL RE-ENROLLMENT REQUIREMENTS

TO STAY COMPLIANT WITH FEDERAL AND STATE REGULATIONS, ALL PROVIDERS MUST REVALIDATE ENROLLMENT EVERY 3 TO 5 YEARS.

- Required under **Title 42 CFR §455.414** and **TAC §371.1015**
- In some cases, revalidation may be required more frequently
- Providers may submit revalidation applications **up to 90 days** before the due date

ADDITIONAL SUPPORT

- **TMHP Contact Center**: 1-800-925-9126 (select Option 3)
- **TMHP-CSHCN Services Program**: 1-800-568-2413 (select Option 2)
- **TMHP Provider Enrollment Webpage**

BILLING AND CLAIMS

Parkland
Community Health Plan

SUBMITTING CLAIMS: FILING DEADLINES & METHODS

TIMELY FILING REQUIREMENTS

MCO	LINE OF BUSINESS	TIMELY FILING REQUIREMENT
Parkland Community Health Plan	STAR & CHIP	Claims must be submitted within 95 days of the date of service (outpatient) or discharge (inpatient).

- **Submit claims promptly** to avoid denials.
- Clean claims are adjudicated **within 30 days** of receipt.
- Appeals must be filed **within 120 days** of the EOP. PCHP will send an **acknowledgment within 5 business days** and **resolve within 30 calendar days** of receipt.

CLAIMS SUBMISSION OPTIONS TIMELY FILING REQUIREMENTS

SUBMISSION TYPE	INSTRUCTIONS
Paper Claims	**Mail to:** Parkland Community Health Plan P.O. Box 560327 Dallas, TX 75356 ***Fax or Handwritten claims*** *are* ***not*** *accepted.*
Electronic Claims	Submit through the PCHP **Provider Portal** For **EDI submissions**, use **Payer ID: 66917**

CLAIMS DISPUTES, APPEALS, AND COMPLAINTS

CLAIMS RESUBMISSIONS AND DISPUTES

For corrected claim, COB information, proof of timely filing:

Parkland Community Health Plan
ATTN: Claims Resubmissions
P.O. Box 560327
Dallas, TX 75356
Online: **PCHP Provider Portal**

COMPLAINTS AND APPEALS

Parkland Community Health Plan Claims
ATTN: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356
Online: **PCHP Provider Portal**

ONLINE SUBMISSION

PCHP Provider Portal

INQUIRIES MUST INCLUDE:

1. Provider's name
2. Date of the incident
3. Description of the incident
4. Time frames

Submit service inquiries to **Provider Services: 1-888-672-2277**

ADVERSE DETERMINATION APPEAL ON BEHALF OF MEMBER

AUTHORIZATION APPEAL

- A provider may appeal an adverse determination of an authorization on behalf of the member.
- Provider is to obtain approval from the member.
- Appeal must be submitted within 60 days of the adverse determination notification.

SUBMIT REQUESTS:

By Fax (Preferred): 1-844-310-1823

By Phone: 1-888-672-2277

By Mail: ATTN: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356

EXTERNAL MEDICAL REVIEW (EMR)

- A provider may request an EMR on behalf of the member if they are in disagreement of the appeal determination.
- An EMR is an optional extra step that can be taken to have the appeal decision reviewed before the State Fair Hearing (SFH).
- An EMR with a SFH must be requested within 120 days of the appeal decision notification.

STATE FAIR HEARING (SFH)

- A provider may request a SFH with or without an EMR on behalf of the member if they are in disagreement with the appeal determination.
- A SFH is when HHSC directly reviews our decisions with your medical care.
- A SFH with or without an EMR must be requested within 120 days of the appeal decision notification.

INDEPENDENT REVIEW ORGANIZATION (IRO)

WHAT IS AN IRO?

An external entity contracted with the Texas Health and Human Services Commission (HHSC) to conduct independent reviews of adverse determinations involving appropriateness of care, medical necessity criteria, level of care, and effectiveness of a requested service.

TIMEFRAMES FOR IRO

- The IRO must complete the EMR and provide determination to PCHP/Member using the following timeframes:
  - Expedited EMR Request: No later than the next business day following receipt of the health plan's records related to the service denial or reduction determination.
  - Standard EMR Request: No later than 10 business days following receipt of the health plan's records related to the service denial or reduction.
- The IRO must ensure that its reviewers are licensed clinical reviewers of the same specialty or area of practice that would generally provide the type of treatment that is the subject of the EMR.

IRO DECISION DETERMINATION

IRO DECISIONS ARE FINAL

The member, authorized representative, and PCHP must be notified by the IRO of its EMR decision in a letter.

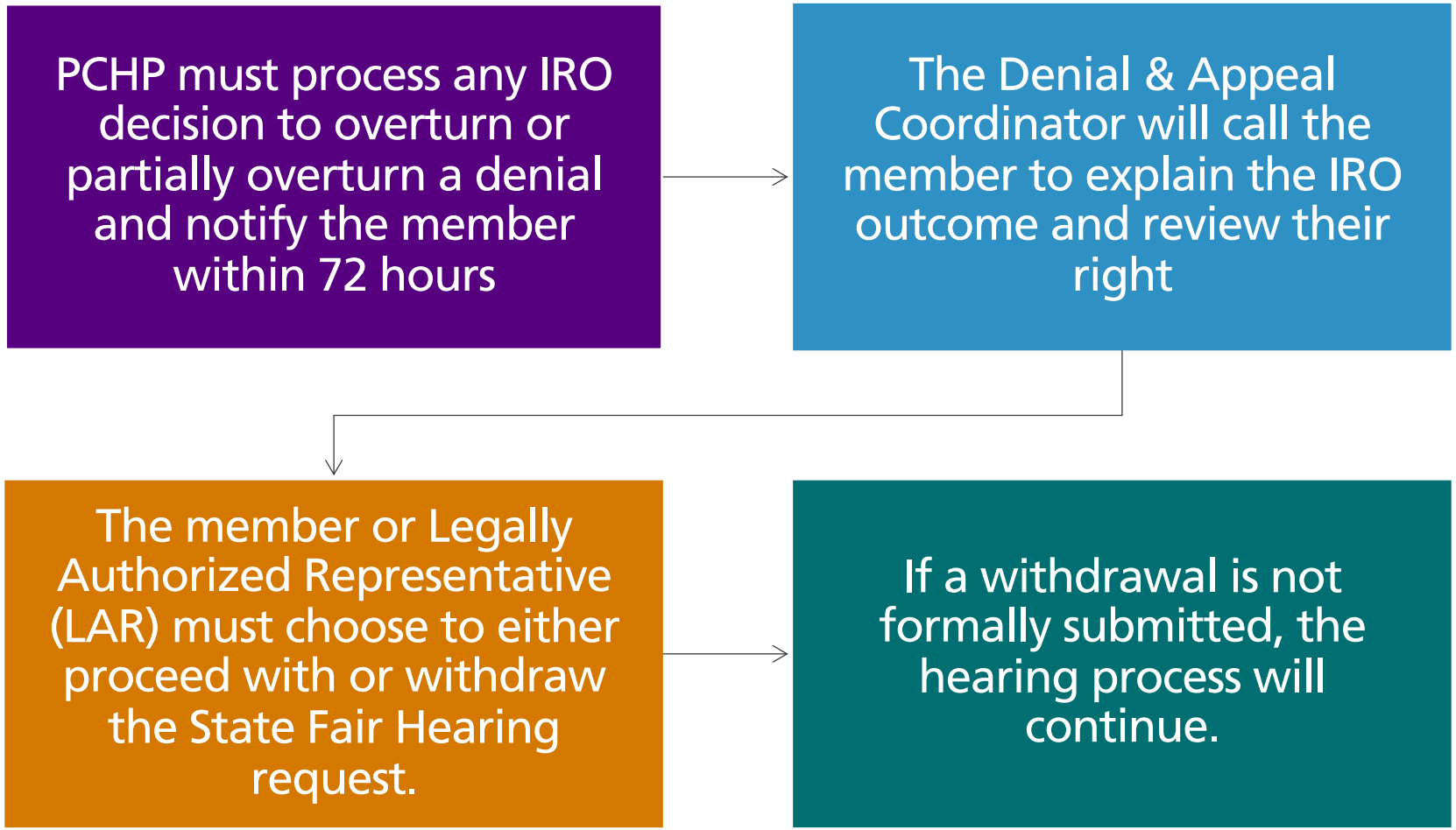
- IRO Decision Notice will be sent via mail.
- For expedited EMR requests, the IRO will send the determination of its EMR decision via secure email.

TYPES OF IRO DECISIONS

- **Overturned**: Completely reverse PCHP's decision to deny/reduce/terminate
- **Partially Overturned**: Partially reverse PCHP's decision
- **Denial Upheld**: Sustain the original decision and agree with PCHP's adverse determination

IRO DECISION DETERMINATION

IRO DETERMINATION AND STATE FAIR HEARING PROCESS



BALANCE BILLING

MEMBERS MUST NOT BE BALANCE BILLED FOR THE AMOUNT ABOVE WHICH IS PAID BY THE HEALTH PLAN FOR COVERED SERVICES.

Providers may not bill a member if any of the following applies:

- Claim was not submitted for initial processing within the 95-day filing deadline
- Corrected claim was not submitted within the 95-day submission period
- Claim appeal was not submitted within the 120-day administrative appeal period
- Utilization review appeal was not submitted within 30 calendar days of denial notification
- Claim was incomplete or unsigned
- Errors occurred during claims preparation, submission, or the appeal process

Providers may not bill a member:

- For failing to show for an appointment
- For a third-party insurance copayment

Providers may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program.

ELECTRONIC FUNDS TRANSFER (EFT) & ELECTRONIC REMITTANCE ADVICE (ERA)

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE OPTIONS

PCHP offers electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers may choose to receive payments electronically via direct deposit and select from the following remittance delivery options:

- ERA available online
- HIPAA-compliant data file for direct download into your practice management or accounting system
- Printed and mailed paper remittance

Providers have two options to enroll in EFT:

1. **Enroll in EFT for PCHP *only*** *(no fees):* **Complete PCHP Enrollment**
2. **Enroll in EFT for all payers** using the Settlement Advocate platform *(a fee will apply):* **Complete All-Payer Enrollment**

For assistance with enrollment or payment options, **contact ECHO Health at 1-888-927-6260.**

FRAUD, WASTE, AND ABUSE (FWA)

Parkland
Community Health Plan

FRAUD, WASTE, AND ABUSE (FWA)

DEFINITIONS AND EXAMPLES

FRAUD	WASTE	ABUSE
Any intentional deception, misrepresentation, or omission made by a person who knows it could result in an unauthorized benefit for themselves or another individual. It encompasses any action that violates federal or state laws governing health care programs.	Any practice a sensible person would consider careless or would cause excessive use of resources, items, or services.	Any practice inconsistent with proper fiscal, business, or medical practices and that causes unnecessary program cost.
EXAMPLES	**EXAMPLES**	**EXAMPLES**
Alteration of claim forms	Overutilization of services that are not medically necessary	Denying/limiting access to medically necessary services
Incorrect coding intended to misrepresent services	Duplication of services already provided	Billing members upfront for services that should be covered by Medicaid/CHIP
Billing for services that were not rendered	Preventable hospital readmissions due to inadequate discharge planning	Allowing ineligible individuals to use someone else's Medicaid ID
Substitution of services (billing for one service while providing another)	Complex, redundant billing processes driving administrative costs	Failure to report third-party liability (TPL) coverage

REPORT FRAUD, WASTE, AND ABUSE

CONTACT THE FOLLOWING:

Parkland Community Health Plan

Online: FWA Situation Referral Form
Phone: 1-888-209-3841
Email: PCHPSIU@phhs.org

Mail: Parkland Community Health Plan
Attention: SIU Coordinator
P.O. Box 569005
Dallas, TX 75356-9441

Compliance Hotline: 1-800-403-2498

Texas HHSC — Office of Inspector General

Online: OIG FWA Referral Form
Phone: 1-800-436-6184

To Report a Provider:
Office of Inspector General
General Investigations
Mail Code: 1361
P.O. Box 85200
Austin, TX 78708-5200

To Report a Member:
Office of Inspector General
General Investigations
Mail Code: 1362
P.O. Box 85200
Austin, TX 78708-5200

Texas Attorney General — Medicaid Fraud Control Unit (MFCU)

Online: MFCU
Phone: 1-800-252-8011 or 512-371-4700
Email: mfcu@oag.texas.gov

Mail: Office of the Attorney General
Medicaid Fraud Control Unit
P.O. Box 12548
Austin, TX 78711

PROVIDER RESPONSIBILITIES FOR PREVENTING FWA

PROVIDERS PARTICIPATING IN TEXAS STAR MEDICAID PLAY A CRITICAL ROLE IN PREVENTING FWA. THEIR RESPONSIBILITIES INCLUDE:

1. Compliance with Medicaid Regulations

- Follow all HHSC and Medicaid & CHIP rules, billing procedures, and policies.
- Stay current on updates to Medicaid provider manuals and applicable state laws.

2. Accurate Documentation & Billing

- Submit accurate, complete, and truthful claims.
- Ensure billed services were actually provided and are medically necessary.
- Avoid upcoding, unbundling, duplicate billing, and phantom billing.

3. Staff Training and Internal Compliance

- Train staff on how to detect, prevent, and report FWA.
- Maintain a written FWA compliance program as required by Texas Medicaid.

4. Monitoring and Reporting FWA

- Conduct internal audits and monitor for FWA risk indicators.
- Report suspected FWA to the Texas OIG Fraud Hotline, the Medicaid Fraud Control Unit (MFCU), or MCOs if applicable

5. Protecting Member Identity

- Verify Medicaid eligibility and confirm member identity before billing.
- Report suspected identity misuse (e.g., multiple Medicaid IDs).

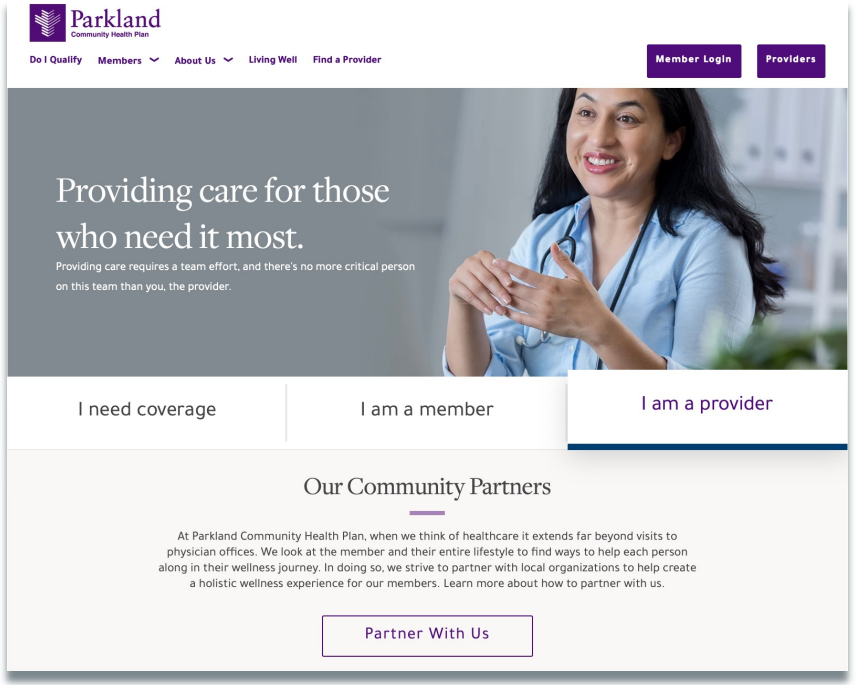
WEBSITE AND ADDITIONAL RESOURCES

Parkland
Community Health Plan

PCHP WEBSITE

AVAILABLE TO PARTICIPATING AND NON-PARTICIPATING PROVIDERS, THE PCHP WEBSITE OFFERS 24/7 ACCESS TO HELPFUL TOOLS AND INFORMATION, INCLUDING:

- Provider manual
- Provider directory and search tool
- Provider newsletters
- Member handbook
- Assistance with member and roster questions
- Secure web portal login
- Forms and provider documents



Visit **Providers.ParklandHealthPlan.com/Login**

PROVIDER PORTAL TOOLS AND ACCESS

THE PCHP PROVIDER PORTAL OFFERS SECURE ACCESS TO TOOLS THAT SUPPORT PATIENT CARE AND DAY-TO-DAY OPERATIONS.

ONCE REGISTERED, PROVIDERS CAN:

- Check member eligibility and coverage.
- View claims and payment status
- Submit and track prior authorizations requests.
- Refer members to Case or Disease Management.
- Submit appeals, complaints, and claim disputes.
- Access the provider directory.
- Download provider forms and documents.
- Update your demographic information.
- Access the MAC (Max. Allowable Cost) portal.
- Get answers to general provider questions.

Need Help? Call Provider Services: 1-888-672-2277.

PROVIDER RELATIONS REPRESENTATIVES

WHAT IS A PROVIDER RELATIONS REPRESENTATIVE?

Every provider is assigned a dedicated provider relations representative who acts as your main point of contact. They serve as the bridge between PCHP and our provider network, helping ensure you have the support and tools you need to succeed.

HOW WE SUPPORT PROVIDERS:

- Education and training
- Demographic updates
- Help with policies, procedures, and day-to-day operations
- Contract support and clarification
- Assistance with member and roster questions
- Provider Portal assistance

WEBSITE TOOLS AND RESOURCES

QUICK REFERENCE

Parkland Community Health Plan (PCHP) Website

- **Provider Home Page**
- **Provider Portal**
- **PCHP Provider Manual**
- **Provider Newsletters**
- **Provider Network News**
- **PA Lookup Tool**

Questions? Reach out to the PCHP Provider Relations team at **PCHP.ProviderRelations@phhs.org**

QUESTIONS?

Parkland
Community Health Plan

THANK YOU!

Provider Services: 1-888-672-2277

Providers.ParklandHealthPlan.com

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