

CookChildren'sSM

Health Plan

801 Seventh Avenue
Ft. Worth, Texas 76104-2796
(800) 964-2247
(682) 885-2247
www.cookchp.org

CHIP

PROVIDER MANUAL

Denton, Hood, Johnson, Parker,
Tarrant, and Wise Counties

March 2009



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I INTRODUCTION



801 Seventh Avenue
Fort Worth, Texas 76104-2796
682-885-2247

Dear Valued CCHP Provider,

Cook Children's Health Plan (CCHP) is a licensed Health Maintenance Organization offered by Cook Children's Health Care System. Cook Children's Health Plan was designed to provide members between the ages of 0 and 18 with quality pediatric health care through the largest pediatric delivery system in North Texas.

Health providers are our valued partners. As a participating provider you will have a key role in the management and provision of health services to plan members. We believe that providers will provide or arrange for the right care, at the right time, in the right care setting for their patients if given the opportunity and sufficient information. It is our objective to allow you to do so, to provide assistance for you and to provide information to you about the outcome of your efforts.

This Provider Manual is designed to be a useful reference when working with Cook Children's Health Plan. It will help you answer questions regarding eligibility verification, claims processing, benefit information and who to call for additional information.

The entire staff of Cook Children's Health plan is pleased to be associated with you and look forward to improving the health care of children throughout the Tarrant Service Area.

Cook Children's Health Plan

I INTRODUCTION

OBJECTIVE

The objective of CCHP is to organize a community of providers to improve access to participant's health care and promote the well being of the members.

BACKGROUND

When you think of Cook Children's, you probably think first of the blue roofed Cook Children's Medical Center downtown in the Fort Worth medical district. Indeed, the children's hospital and the Cook Children's Physician Network comprise a key component of the system of pediatric care in our community. Cook Children's also operates a Health Maintenance Organization (HMO), Cook Children's Health Plan (CCHP). CCHP is a unique HMO created to provide CCHP members with a full range of quality health care.

CCHP received a Certificate of Authority (COA) from the Texas Department of Insurance in February 1999 as a licensed HMO. For the last several years, CCHP successfully operated the HMO offering the Children's Health Insurance Program (CHIP) product which provides low cost insurance for children unable to enroll in Medicaid and unable to afford traditional commercial insurance. The service area for the CCHP program includes Denton, Hood, Johnson, Parker, Tarrant and Wise counties.

CCHP provides you, your office staff, and your CCHP members with very high standards of customer service to help eliminate the hassle factor often associated with HMO's. CCHP goes the extra mile to resolve any issues that arise quickly. We continually want feed back on how we can serve you better. Providers we work with have often told us that they enjoy the following benefits of CCHP participation:

- Electronic eligibility verification (24/7) through CCHP's website
- No referral requirements to network specialists and minimal precertification
- The ability to have electronic claims submission directly to CCHP
- Electronic claims status check to assist you with accounts receivable management
- Timely claim turnaround with a 99.9% accuracy rate
- Locally based Care Management, Provider Relations, and Member Services staffs.
- Health plan operations that have been given one of the highest provider satisfactions scores in the State of Texas
- A health plan committed exclusively to the needs of federally funded participants in the greater Tarrant service area.

CCHP welcomes you as a participating provider in our network. Call CCHP at 800-947-2247 or 682-885-2247 if we can assist you.

I INTRODUCTION

QUICK REFERENCE PHONE LIST

General Mailing Address

Cook Children's Health Plan
P. O. Box 2488
Fort Worth, TX 76113-2488

Departments

Member Services

Main Number - 682-885-CCHP (2247)

Toll free - 800-964-CCHP (2247)

Fax - 682-885-8401

Please call the Member Services Department for member eligibility, benefits, or general questions.

Claim Inquiries

Main Number - 682-885-CCHP (2247)

Toll free - 800-964-CCHP (2247)

Fax - 682-885-8404

Please call the Claims Department for claims status, payments, appeals or questions.

Care Management

Main Number - 682-885-2252

Toll free - 800-862-CCHP (2247)

Fax - 682-885-8402

Please call the Care Management Department for more information regarding prior authorization for certain services, patient notification, and catastrophic case management.

Network Development

Main Number - 682-885-CCHP (2247)

Toll free - 800-964-CCHP (2247)

Fax - 682-885-8403

Please call the Network Development Department for general questions, complaints, Provider Manual, an orientation or a current provider directory.

Contracting

Main Number - 682-885-4485

Toll free - 800-964-CCHP (2247)

Fax - 682-885-2148

Please call the Contracting phone number should you know of a physician or other provider you wish to refer who is not currently participating with CCHP.

I INTRODUCTION

Ancillary Provider Information

<u>Laboratories</u>	Quest Laboratories	800-824-6152
	LabCorp	972-566-7500 option 7

Please contact this number for all inquiries regarding new accounts, STAT labs, supplies, and requisitions.

<u>Pharmacy</u>	CHIP Prescription Drug Benefit	800-435-4165
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<u>Behavioral Health</u>	LifeSynch	800-890-8288
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<u>Vision Services</u>	Opticare	800-465-6853
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<u>Dental Services</u>	Delta Dental	866-531-5892
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Other Important Information

ACS Provider Hotline	800-645-7164
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CHIP	800-647-6558
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(CHIP is responsible for determining member eligibility and enrolls and/or disenrolls individuals)

CHIP/Medicaid Outreach Program	877-543-7669 (877-KIDS-NOW)
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Access on the World Wide Web

Cook Children's Health Plan	www.cookchp.org
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Texas Health & Human Services	
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Commission	www.hhsc.state.tx.us/medicaid/mc/about/faq.htm
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CCHP Eligibility and Claim Status	www.cookchildrenshealthplan.org
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Translation Services

CCHP provides translation services for members who speak languages other than English. Call Member Services at (682) 885-CCHP (2247) or (800) 964-CCHP (2247) for assistance. A Member Services Representative will put you in touch with someone who speaks their language.

CCHP offers Relay Texas TDD services for members who have a hearing loss. Call CCHP's TDD line at (682) 885-2138 and a Member Services Representative will be able to help you.

II PROVIDER RESPONSIBILITIES

PROVIDER RESPONSIBILITIES

Each member of the COOK CHILDREN'S HEALTH PLAN (CCHP) must select a Primary Care Provider (PCP). The PCP provides all primary care services within the scope of the provider's practice and is responsible for coordinating all health care services required by the member. The Specialty Care Provider (SCP) provides diagnostic treatments and/or management options, tests and treatment plans, as requested by the PCP. Primary Care and Specialty Care Providers shall offer member access to covered services 24 hours a day 7 days a week. Such access shall include regular office hours on weekdays and availability by telephone outside of such regular hours including weekends and holidays. CCHP has no carve-outs; therefore, there are no network limitations. Providers may refer to any contracted specialists or OB-GYN in the network.

Access Standards

Access to Primary Care Providers, Specialty Care Providers, Ancillary Providers, and Network Facilities - Providers must be available to members as follows:

Primary Care	
Preventative	Within 14 days of enrollment for newborns. Within 60 days for all other children
Routine Care	Within 14 days of request
Urgent Care	Within 24 hours
Emergency Care	Upon presentation
Office Wait Time	0-30 minutes on average for scheduled appointments
Specialty Care	
Routine Care	Within 30 days of request
Prenatal Care (routine)	Within 14 days
Prenatal (high risk or New Members in 3 rd trimester)	Within 5 days or immediately if an emergency exists
Initial Outpatient Behavioral Health visits	Within 14 days

Telephone Access

Standard 0-5 rings or 0-30 seconds

After-hours Provider Care - The Provider is required to provide twenty-four hour on-call coverage. Please keep CCHP updated with changes to your on-call providers. The answering service or paging mechanism must provide a response to a Member call within thirty minutes.

II PROVIDER RESPONSIBILITIES

After-hours Urgent: 24 hours/day, 7 days per week

After-hours Call Back Time:

Emergent Situations: 0 - 30 minutes

Urgent Situations: 0 - 30 minutes

Routine: within 24 hours

“Emergent” is defined as a condition if left untreated could be potentially life threatening.

“Routine” includes non-emergency check-ups, physicals, tests or non-urgent surgeries.

“Urgent” is defined as a condition that is not imminently life threatening but requiring care within 24 hours.

Emergency Medical Condition

CCHP follows the Texas Health and Human Services Commission definition of 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 patient’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 woman, serious jeopardy to the health of a woman or her unborn child.

An emergency behavioral health condition 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.

CCHP does not require prior authorization or notification of emergency care (emergency room or ambulance).

II PROVIDER RESPONSIBILITIES

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.

Urgent behavioral health situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Routine Care

Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Emergency Transportation

CCHP covers ambulance transportation in the following circumstances:

- **Emergency**
In the event a Member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require CCHP prior authorization.
- **Non-Emergency Transportation**
All non-emergency ambulance transports must be prior authorized by CCHP before transport services are rendered.

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 non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or PA edit and would need prescriber prior approval.

Member Acknowledgement Statement (Explanation of Use)

A provider may bill a CCHP Member for a service that has been denied as not medically necessary or not a covered benefit only if **both** of the following conditions are met:

- The member request the specific service or item; and
- The provider obtains and keeps a written Member Acknowledgment Statement which states:

II PROVIDER RESPONSIBILITIES

“I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items are determined not to be reasonable and medically necessary for my care.”

Private Pay Statement

A provider may bill the following to a Member without obtaining a signed Client Acknowledgment Statement:

- A service that is not a benefit of the CHIP or CCHP programs (i.e., experimental or investigational services).
- The provider accepts the Member as a private pay Member. Providers must advise Members that they have been accepted as private pay Members at the time the service is provided and will be responsible for paying for all services received. In this situation, HHSC encourages that notification be in writing with the Member’s signature so there is no question how the Member was accepted. The provider should not seek payment from an eligible CHIP Member without written, signed documentation that the Member has been notified of the pay status.

A provider who attempts to bill or recoup money from a CCHP Member in violation of the above situations may be reported to the appropriate fraud and abuse unit and excluded from the Texas Medicaid program.

Private Pay Agreement (Sample)

I understand (Provider Name) is accepting me as a private pay patient from _____ to _____. I will need to pay for any services that I receive during this time. (Provider’s name) will not file a claim to Cook Children’s Health Plan or Medicaid for services provided to me.

Signed: _____

Date: _____

TERMINATION

Provider Requests Termination

If provider chooses to leave the network, a 90-day written notice is required. Refer to the Term and Termination Section of your Service Agreement.

Termination of Provider by CCHP

CCHP may terminate a provider’s participation in the health plan in accordance with its participation contract with the provider and any applicable appeal procedures.

II PROVIDER RESPONSIBILITIES

Automatic Action - A provider's participation in CCHP shall be automatically terminated for any of the following:

- Loss, suspension, or probation of professional licensure, certification, or registration;
- Loss of either state or federal or both controlled substances registration;
- Loss of required professional liability insurance coverage;
- Exclusion from the Medicare, Medicaid, or any other federal health care program; or
- For providers, failure to meet the board certification requirement unless granted an exception as set forth in the criteria.

ATTENTION TO FEMALE MEMBERS

Members have the right to select an OB/GYN without a referral from their PCP. Access to health care services by an OB/GYN include:

- one well-woman check-up per year
- care related to pregnancy
- care for any female medical condition
- referral to special doctor within the network

All pregnancies are required to be reported to the Care Management Team at CCHP. Please refer to the Pregnancy Notification and Delivery Notification forms located in the Forms section of this manual.

ADVANCE DIRECTIVE

CCHP Members have the right to make choices about their health care treatment and mental health care treatment. CCHP Members can choose the care they want or don't want, as well as choose not to accept care or to stop care. These choices should be made by the Member before he or she becomes ill in the form of an Advance Directive, or for mental health treatment, in the form of a Mental Health Advance Directive. CCHP Members who have questions or would like additional information about Advance Directive can call CCHP Member Services at **682-885-2247** or **800-964-2247**. CCHP Providers are responsible for advising Members of their right to sign an Advance Directive Form.

REFERRALS

The Provider is responsible for initiating the prior authorization process when a member requires medical services or inpatient admission. A specialist may refer to another specialist if the PCP is notified and concurs with the referral. **Any referral from an in-network primary care physician to an in-network specialist (for evaluation only), facility, or contractor does NOT require prior authorization. Some treatment(s) may require prior authorization when performed by an in-network provider. All out-of-network referrals MUST receive prior authorization from the CCHP**

II PROVIDER RESPONSIBILITIES

Medical Director. Out-of-network referrals are required when services are unavailable from a CCHP in-network provider, facility or contractor.

Members may access the following services without referral: emergency services; OB/GYN services; Vision Services and behavioral health services.

OB/GYN Services - CCHP does not limit the selection of an OB/GYN to their PCP's network. Nor does CCHP require a referral to an OB/GYN provider.

Emergency Services – CCHP pays for emergency services in and out of the area. Emergency service is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

The provider should direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition exists. If an emergency condition does not exist, the provider should direct the member to a CCHP participating office. CCHP does not require that the member receive approval from the health plan or the PCP prior to accessing emergency services. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency services. Providers are not required to notify CCHP Care Management about emergency services.

If the provider receives a request for authorization of post-stabilization treatment, the provider must respond to the emergent/urgent facility within one (1) hour. If the facility does not receive a response within one (1) hour, the post-stabilization services shall be considered authorized in accordance with Texas Department of Insurance statutes. The provider shall notify CCHP of all post-stabilization treatment requests.

Vision Services – Members may contact a vision provider listed in their provider directory. A vision screening is an examination by an optometrist or other provider to determine the need for and to prescribe corrective lenses and frames.

Behavioral Health – CCHP has contracted with a behavioral health provider to provide mental health and substance abuse services to members. Members may call the behavioral health provider indicated on the member's ID card.

II PROVIDER RESPONSIBILITIES

Special Note on Mental Health Referrals

We all recognize that the prevalence of psychosocial complaints and chemical dependency disorders are high. Providers should make every effort to elicit and diagnose these problems. CCHP considers it to be part of the Provider's scope of care to provide basic evaluation for some of these problems, from attention deficit disorder, to chemical dependency, to depression, and anxiety states.

Should you encounter any Member who appears to be in need of mental health or chemical dependency services, please direct that Member to the behavioral health provider network indicated on the Member's ID card. In such instances, a Referral is not required. Should CCHP alter its arrangements for such services, CCHP will notify Provider.

ACCESS TO SECOND OPINION

CCHP ensures that each Member has the right to a second opinion regarding the use of any medically necessary covered service. Either a Member or an in-network provider may request a second opinion. The second opinion must be obtained from a network provider. If a network provider is not available, the member may obtain the second opinion from an out-of-network provider at no additional cost to the member. All out-of-network requests require prior authorization of the CCHP Medical Director. CCHP may also request a second opinion. The reasons include, but are not limited to:

- A member or provider voices a concern about care;
- When an experimental or investigational service is requested;
- Possible outcomes or risks of requested treatment are identified by CCHP;

When CCHP requests a second opinion, CCHP will arrange the appointment and notify the member and PCP of the date and time of the appointment. CCHP will request that the consulting provider send his/her opinion to the PCP and CCHP. The PCP will notify the member of the consultant's opinion and recommendations.

COORDINATION WITH NON-CHIP MANAGED CARE COVERED SERVICES

Texas Agency Administered Programs and Case Management Services: Texas Department of Family and Protective Services (DFPS) – CCHP works with DFPS to ensure that the at-risk population, both children in custody and not in custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out of CCHP more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area. During this transition, providers must:

- Provide medical records to DFPS;
- Schedule medical and behavioral health services appointments within fourteen (14) days unless requested earlier by DFPS;
- Refer suspected cases of abuse or neglect to DFPS.

II PROVIDER RESPONSIBILITIES

A member in the custody of DFPS may continue to receive services until he or she is disenrolled from CCHP due to loss of Medicaid managed care eligibility or placement in foster care.

Essential Public Health Services: CCHP is required by its contractual relationship with HHSC to coordinate with Public Health Entities for the provision of essential public health services. Providers must assist CCHP 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 notification or referral 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 persons with 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 with whom the member has come into contact;
- Referring to 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; and,
- Referring lead screening tests to the TDH Laboratory.

ELIGIBILITY AND BENEFIT COVERAGE VERIFICATION

The Health and Human Service Commission (HHSC) will make the final decision regarding eligibility, enrollment, disenrollment and automatic re-enrollment. Providers cannot take retaliatory action against members when a member is disenrolled from Managed Care or from a provider's panel. Any request from a member for disenrollment from managed care will require medical documentation from their PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

Please Note: Eligibility must be verified prior to providing services.

- a. Photocopy the Member ID card. In some cases, the member may need to access services before he/she receives an ID card. The letter that the member receives notifying him/her of the eligibility date may be used as member identification until the member receives the ID card. **Possession of an ID card does not verify eligibility.** Please see Section VII as co-payment amounts may vary.

II PROVIDER RESPONSIBILITIES

- b. Call Member Services at **(682) 885-CCHP (2247)** or (800) 964-CCHP (2247) to verify eligibility and coverage. It is recommended that the Provider verify member eligibility each time a CCHP member accesses services.
- c. The PCP receives a monthly Member Eligibility Report that identifies the PCP's CCHP Membership.
- d. CCHP offers on-line services to verify eligibility
- e. Refer to Member Handbook Section for a description of CHIP benefits and copy of the Member ID Card.
- f. Re-enrollment must occur every 12 months for a member to have continuous coverage. If a member does not re-enroll within the specified time frame they will be disenrolled and ineligible to re-enroll for 90 days.

The Physician must verify that services are a covered benefit prior to rendering services. If a service is not a covered benefit, the Physician may bill the member only if written prior authorization for the non-covered service is obtained from the member prior to rendering the service. Please reference your CCHP agreement for more information.

Disenrollment

Disenrollment may happen if a member is no longer eligible for CHIP. A member may lose CHIP eligibility if:

- A member turns nineteen
- A member does not re-enroll by the end of the 12 month coverage period;
- A member does not pay premium when due or within the grace period
- A member is covered under another health plan through an employer
- Death of a member
- A member moves out of the states; or
- A member is enrolled in Medicaid

A provider cannot take retaliatory action against a member if they are disenrolled.

Plan Changes

Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause.

Eligibility

All CCHP providers are responsible for verifying eligibility prior to providing care to members. There are several ways this can be done: through member identification cards, through telephone verification, membership listings, and through CCHP's online enrollment eligibility site, www.cookchildrenshealthplan.org. CCHP recommends that providers verify eligibility through all available means prior to providing care to members.

II PROVIDER RESPONSIBILITIES

Verifying Eligibility

CookChildren's Health Plan
Member Identification Card
(Tarjeta de Identificación de Socio)

Member Name: <i>Nombre de Miembro</i>	DOB: <i>Fecha de Nacimiento</i>	Member Service: (8:00 a.m.–5:00 p.m.) disponible 24 horas a día (682) 885-CCHP (2247) <i>Servicio Para Miembros Disponible 24 horas al día (800) 964-CCHP (2247)</i>
ID No: <i>Número de ID</i>	Plan Eff. Date: <i>Fecha de efectiva del Plan</i>	For an Emergency: Call 911 or go to the nearest emergency room <i>Para una Emergencia: Marque 911 o vaya al centro de emergencia más cercano</i>
PCP: <i>PCP</i>	PCP Phone: <i>Teléfono de PCP</i>	Prescription Drug: Call Vendor Drug Program (866) 276-9154 <i>Recetas: llame a Vendor Drug Program</i>
PCP Effective Date: <i>Fecha de efectiva de PCP</i>	Plan: <i>Plan</i>	CHIP Vision: (800) 465-6353 <i>Visión de CHIP</i>
RX Benefit: <i>Beneficio de farmacia</i>	Benefit: <i>Beneficio</i>	CHIP Behavioral Health CorpHealth: Available 24 hours a day (866) 258-0942 <i>CorpHealth para Salud Mental de CHIP Disponible 24 horas al día</i>
Brand: <i>Marca</i>	OPV: <i>Título de Oficina</i>	Note: All health care services must be authorized or performed by the member's PCP. Authorizations must be obtained before services are provided. Failure to obtain prior authorization (except emergencies) may result in nonpayment of claims. <i>Note: Toda cuidado de salud tiene que ser autorizado o prestado por el PCP. Autorizaciones tienen que ser obtenidas antes de que se presten servicios. Falta de obtener autorización previa (excluyendo emergencias) puede causar que no se paguen los reclamos.</i>
Generic: <i>Genérico</i>	ER: <i>Emergencia</i>	Send Claims to: Cook Children's Health Plan Claims <i>Envíe Reclamos a:</i> P.O. Box 300247, Houston, TX 77230

Note: This card does not guarantee coverage. Call (800) 964-2247 to confirm member eligibility.
Note: Esta tarjeta no garantiza cobertura. Llame a (800) 964-2247 para confirmar elegibilidad.

Call Health Plan

Providers are responsible for verifying a member's eligibility, identifying which plan a member is assigned to, and identifying the name of the assigned PCP at each visit by contacting the Member Service department of the member's primary HMO.

The phone number for CCHP's Member Service department is as follows:

Local Number (682) 885-2247

Toll Free Number (800) 964-2247

Value Added Services

- **Obesity Reduction** –CCHP will provide a structured program for members suffering from obesity (BMI \geq 95% for age or 85% and significant comorbidities) that includes registration and payment for Weight Watchers classes. The Member must be referred to the program by the Member's Primary Care Physician.

Limitations or Restrictions: Benefits limited to members with a BMI \geq 95% for age or 85% and significant comorbidities. These programs will be authorized and available only at designated Weight Watchers meeting sites. Member must have a documented weight loss of at least 4 pounds over an eight week period in order to continue on the Weight Watchers program. Members who miss more than one Weight Watchers meeting in a six weeks period will be disenrolled from the Weight Watchers program. This benefit will be limited to children 10 years of age and older.

- **Increased Frame Allowance (Vision Services)** – Members will be eligible for a frame allowance of \$75.00.
- **Sports/School Physicals** –CCHP will provide one Sports/School Physical per calendar year to enrolled members that are under the age of 19.
Limitations or Restrictions: Benefit is limited to one physical per calendar year for members under the age of 19.

II PROVIDER RESPONSIBILITIES

- **First Aid Kit** –CCHP will provide a coupon for a First Aid Kit for each Member that includes a voucher for over the counter medication, band aids, antiseptic, thermometer and other first aid items.
Limitations or Restrictions: Benefit limited to one kit per member per calendar year.
- **Prepared Childbirth Classes** –CCHP will provide coverage for up to \$70.00 for prepared childbirth Lamaze and breast feeding classes.
Limitations or Restrictions: Classes are limited to one program enrollment per pregnancy.
- **Over the Counter Drug Benefit** –CCHP will provide a maximum of \$15.00 in reimbursement for over- the -counter medication for all new members.
Limitations or Restrictions: Member must send receipts to CCHP once total reaches \$15.00 for reimbursement.
- **Safety Package** – Cook Children’s Health Plan will provide all members from 0-3 years of age with a safety package that includes items such as plug covers, cabinet latches and choke tubes upon receipt of the completed flyer requesting the safety package.
Limitations or Restrictions: Benefit is limited to one safety package per member per year. Member must submit the value added benefit flyer contained in the new member packet in order to receive the safety package.

MEMBER RIGHTS AND RESPONSIBILITIES

The following is a list of member rights received upon enrollment with CCHP:

MEMBER RIGHTS

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Meaning, you cannot see all the doctors who are in your health plan. If your health plan uses “limited networks,” you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same “limited network.”
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to

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- your child. You have a right to know what those payments are and how they work.
4. 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.
 5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
 6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
 7. If your child is confirmed to have special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
 8. Children who are confirmed to have special health care needs or a disability have the right to special care.
 9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask you plan about how this works.
 10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
 11. You have a right to emergency services when you need them 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 few dollars depending on your income.
 12. You have the right and responsibility to take part in all the choices about your child's health care.
 13. You have the right to speak for your child in all treatment choices.
 14. You have a right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
 15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.

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16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it won't pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. Try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. Become involved in the doctor's decisions about your child's treatments.
3. Work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, try to first resolve it using the health plan's complaint process.
5. Learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
6. If you make an appointment for your child, try to get to the doctor's office on time. If you can't keep the appointment, be sure to call and cancel it.
7. If your child is in the CHIP program, you are responsible for paying your doctor and other provider's co-payments that you owe them.
8. Report misuse of the CHIP program by health care providers, other CHIP members, or CHIP health plans.

II PROVIDER RESPONSIBILITIES

The following CHIP provider marketing policy is consistent with Texas Department of Insurance standards.

CCHP Provider Marketing Policy for CHIP

1. Health care providers may undertake a variety of activities designed to encourage families to apply to the CHIP. Examples include, but not limited to:
 - a) Displaying posters, brochures, or other written material
 - b) Distributing application booklets to families with uninsured children
 - c) Playing a video that promotes CHIP
 - d) Informing their patients of the toll-free CHIP hotline
2. Providers may educate their patients about CHIP specifically.
3. Providers may **not** promote the selection of specific health plans within the context of the CHIP enrollment process.
4. Providers may **not** assist families in filling out the health plan selection form.
5. Providers may **not** distribute health plan marketing materials in their offices.

CCHP Patient Education Policies for CHIP

1. Providers may inform their patients regarding the plans in which they participate.
2. Providers may inform their patients of the benefits, services, and specialty care providers offer through the CHIP plans in which they participate.
3. At the patients' request, providers may give patients the information necessary to contact a particular health plan.
4. Providers may distribute or display written health educational materials or health related posters (no larger than 16 x 24) provided it is done for all plans in which the providers participate; these materials may have the health plan's name, logo, and phone number.
5. Providers may display plan stickers (no larger than 6"x 8") indicating they participate with a particular Health Plan as long as they do not indicate anything more than "health plan is accepted or welcomed here." In the case of CHIP-specific materials, stickers must feature the CHIP logo.

TERMINATION FOR GIFTS OR GRATUITIES

Network Provider may not offer or give any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than \$50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. The MCO may terminate this Network Provider contract at any time for violation of this requirement.

II PROVIDER RESPONSIBILITIES

FREQUENTLY ASKED QUESTIONS

In discussing CHIP with my patients, may I say “If you want to continue seeing me as your physician, you must select [names of all plans in which you participate] as your health plan(s) when you are completing the enrollment form”?

Answer: Yes. To reiterate the intent of the policy, however, a provider who participates in more than one CHIP health plan must mention each plan and this must happen in a way that does not cast one plan in a more favorable light than the others.

If I am enrolled in more than one CHIP health plan network, do I have any responsibilities in mentioning both of them to my patients?

Answer: If you participate in more than one CHIP health plan, and you are discussing CHIP with a patient, you must mention your participation in each of the plans or not mention them at all. You may not indirectly promote one plan by failing to refer to the other one.

Can someone in my office help a family complete the CHIP application?

Answer: Yes.

Can someone in my office help a family complete the CHIP health plan selection form?

Answer: No. Texas Department of Insurance standards does not permit providers to become directly involved in the health plan selection or enrollment process. Enrollment will be conducted centrally by CHIP.

May I distribute to my patients free items that display health plan information?

Answer: No. Providers may not give out or display health plan marketing materials or items, including giveaways.

FRAUD REPORTING

If you suspect a client (a person who receives benefits) or a provider (e.g., doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

Reporting Provider/Clients Waste, Abuse and Fraud

You can report provider/clients directly to your health plan at:

Cook Children’s Health Plan
P.O. Box 2488

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Fort Worth, TX. 76113-2488
1-800-964-2247

Or if you have access to the internet go to HHSC website at <http://www.hhs.state.tx.us> and select “Reporting Waste, Abuse, and Fraud”. The site provides information on the types of waste, abuse, and fraud to report. If you do not have internet access and prefer to talk to a person, call the Office of Inspector General (OIG) Fraud Hotline at 1-800-436-6184, or you may send a written statement to the following OIG addresses:

To report providers, use this address:

Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
P.O. Box 85200
Austin, TX. 78708-5200

To report clients, use this address:

Office of Inspector General
General Investigations/Mail Code 1362
P.O. Box 85200
Austin, TX. 78708-5200

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

- When reporting a provider (e.g., doctor, dentist, counselor, etc.), provide the following:
 - Name, address, and phone number of provider
 - Name and address of the facility (hospital, nursing home and home health agency, etc.)
 - Medicaid number of the provider and facility is helpful.
 - Type of provider (physician, physical therapist, and pharmacist, etc.)
 - Names and number of other witnesses who can aide in the investigationInvestigation:
 - Dates of events
 - Summary of what happened
- When reporting a client (a person who receives benefits), provide the following:
 - The person’s name;
 - The person’s date of birth, social security number, or case number if available;
 - The city where the person resides; and
 - Specific details about the waste, abuse or fraud.

II PROVIDER RESPONSIBILITIES

SPECIAL ACCESS REQUIREMENTS

Ambulance

Ambulance services are covered for Medicaid members in emergency situations. See the “Emergency Services” section of this manual for information regarding emergencies. Providers who have severely disabled member whose condition requires ambulance services may request approval for an ambulance by using a Prior Authorization Request Form.

CULTURAL COMPETENCY

Reading/Grade Level Consideration

All CCHP member materials, such as the Member Handbook and correspondence, are written at a 6th grade level in both English and Spanish. Other languages will be provided when the language required is spoken by 10% or more of the enrolled population.

Sensitivity and Awareness

Cultural and linguistic competency is defined as a set of linguistic, human interaction, and ethnic, cultural, and physical and mental disability awareness skills that permit effective communication and interaction among human beings. The term *culture*, in this definition, also includes the beliefs, rituals, values, institutions and customs associated with racial, ethnic, religious or social groups and individuals of all nationalities. Understanding and maintaining sensitivity to all of the factors that impact human behavior, attitudes and communications is integral to assuring the provision of quality, compassionate and effective health care services to the members of CCHP.

Cultural (or multicultural) competency is addressed in this plan from two perspectives:

- human interaction and sensitivity; and,
- culturally effective health care services to CCHP members by network providers.

Physicians and other health care practitioners are compelled to understand the customs, rituals, and family values of the various cultural groups (in addition to assuring effective linguistic translations/communications) of their patients in order to provide quality and effective health care.

Within the service area of CCHP, many diverse cultural groups are represented. It is the beliefs, customs, languages, rituals, values and other aspects of the North Texas regional population which must be understood and addressed by CCHP staff and affiliated providers in order to provide quality service and quality, effective health care. CCHP will, as part of this Plan, conduct an education and training program on cultural competency described below:

Employee Training – CCHP hires a diverse group of employee in all levels of our organization. CCHP does not discriminate with regard to race, religion or ethnic background when hiring staff. All new employees will be trained on this Plan during CCHP’s new employee orientation. All employees will have access to the Plan as a guide for providing culturally competent services to our members.

II PROVIDER RESPONSIBILITIES

Provider Training – CCHP contracts with a diverse provider network. CCHP’s providers speak a wide array of languages including Spanish, Vietnamese, Chinese and Hindi to name a few. CCHP’s Provider Directory includes the languages spoken in the provider offices to assist our members with selecting a provider that would meet their medical needs as well as having the ability to directly speak to the provider in their language. All providers that are new to the Health Plan receive an initial orientation which includes information about this Plan. All providers also receive education and training on an ongoing basis.

Providers should educate themselves about the health care issues common to different cultures and ethnicities. When an encounter with a patient is difficult due to cultural barriers, they should prepare for future visits by researching and asking for the patient’s input.

Newsletters – CCHP develops members’ newsletters on a quarterly basis and providers’ newsletters on a bi-monthly basis. These newsletters are used to communicate information to our members and providers about any new information of interest. It is also used as a tool to remind our members and providers about various aspects of this Plan.

Member Handbook – CCHP’s member handbook is sent to every new member that joins our Health Plan. The member handbook includes information about our Cultural Competency and Translation Services Plan. Information included in the handbook consists of an explanation of the translation services available to our members, the ability to speak to a Spanish speaking Member Services Representative, the ability to communicate with our health plan using the TDD/TTY phone as well as information requesting the member materials in ways to assist members with other disabilities such as materials for the visually impaired.

LANGUAGE TRANSLATION SERVICES

CCHP provides several options for the non-English speaking or hearing-impaired CCHP members (or their parents) to communicate with CCHP. These options are described below.

In-house Translation Services

CCHP employs bilingual staff members in the Member Services, Claims, Marketing and Care Management departments. CCHP’s bilingual staff is available by contacting CCHP Monday through Friday from 8:00 a.m.– 5:00 p.m. by calling 1-800-964-2247.

Cyra Communications

CCHP subscribes to CyraCom International (CyraCom), a translation service offering competent translations of most commonly spoken languages around the world. CCHP staff is trained in how to access this line in order to communicate with members from essentially all local ethnic groups. CyraCom interpreters have received special training in terminology and standard business practices in the HMO and healthcare industries.

II PROVIDER RESPONSIBILITIES

All CyraCom operators are trained in the following key areas:

- Facilitate emergency room and critical care situations
- Accelerate triage and medical advice
- Simplify the admitting process
- Improve billing and collection processes
- Process insurance claims
- Process prescriptions
- Provide outpatient and in-home care
- Change primary care providers
- Communicate with non-English speaking family members

CCHP members can access the CyraCom translation services by calling the main number to CCHP at (800) 964-2247 or (682)-885-2866. A CCHP staff member will conference in a CyraCom translator who can facilitate the communication.

Multi-lingual Written Member Materials

All published member materials will be available in both English and Spanish. Whenever a particular segment of the CCHP population reaches ten (10) percent or more of the total population, materials will be translated into the predominant language of that population.

Multi-lingual Web Site for CCHP

CCHP has established and maintains a web site for CCHP members in both English and Spanish. CCHP's website is constructed such that members with access devices that have industry-standard technological capabilities can easily access and surf the web site. The web site will be translated into additional languages as that specific segment of the population reaches ten (10) percent or more of the total population. The CCHP website for members is: www.cookchp.org.

Multi-lingual Recorded Messages

CCHP will record all voice messages on its main business lines and Member Services Hotline/Call Center in both English and Spanish. When a particular segment of the CCHP population reaches ten (10) percent or more of the total population, recorded messages will be added to main business lines in the predominant language of that additional population (or populations).

Provider Directory Language Information

The Provider Directory published by CCHP will be in both English and Spanish (and other languages when needed as described above) and will identify providers who are proficient in various languages. This information will help CCHP members select providers who are culturally compatible with their family and who can communicate effectively with the member(s).

Reading Level Sensitivity

II PROVIDER RESPONSIBILITIES

Because of the cultural diversity of the CCHP population, not all members have comprehensive reading levels. Therefore, in order to facilitate understanding, all written CCHP materials (including the web site) will be at or below a sixth (6th) grade reading level. This will be accomplished by testing all text with a software tool called “Readability”- Set I.

SERVICES FOR HEARING, VISUAL, & ACCESS IMPAIRED

CCHP has many years of experience within the organization in communicating with children and family members who are either visually or hearing impaired or both. In addition, CCHP accesses all CCHCS resources available on an as-needed basis to assure effective communications with its hearing and visually impaired members and their families.

Services for the Hearing Impaired

CCHP has a service agreement with Texas Interpreting Services (TIS). This company employs 75 staff members who are proficient in sign language communications for hearing impaired individuals. These services are available to CCHP staff and providers on an as-needed basis. If a provider is in need of a sign language interpreter, they can contact CCHP at least 5 days in advance of the scheduled appointment and CCHP will coordinate services with TIS.

Telecommunications Devices for the Deaf (TDD)

CCHP employs telecommunications devices that can effectively communicate with hearing impaired members. Whenever a “silent call” is received on the CCHP Member and/or Provider Hot Line, staff will handle such calls by utilizing telephonic communications devices that permit the representative to communicate with the member/caller using the TDD/TTY.

Internet Member Services Access

In addition, members who are hearing impaired may communicate via electronic mail (e-mail) over the internet, whenever the member has access to such services, for all of their business relative to the CHIP.

Services for the Visually Impaired

CCHP also provides alternative communication services for members/families that are visually impaired. These services include:

- Verbal communications and assistance via phone or in person to assist the member with:
 - Understanding plan benefits;
 - Selecting an appropriate primary care provider;
 - Resolving billing or other questions; and,
 - Other concerns or questions regarding their plan or plan benefits.

II PROVIDER RESPONSIBILITIES

- Audiotape versions of the Member Handbook and other member communications regarding the plan or plan benefits and limitations are available upon request.

Access to Services for Members with Physical and Modality Limitations

As part of the inventory of items that CCHP Network Development staff checks when performing on site office survey visits to network provider offices/locations, information is gathered to determine if the facilities provide access for members with physical and mobility limitations. The results of the audits are documented and reported to the Quality Management Committee on a quarterly basis.

Providers are required to meet the minimum standards for access prescribed by the Americans with Disabilities Act (ADA) and terms and conditions outlined in the CCHP provider services agreement.

CONTINUITY OF CARE

CCHP recognizes the importance of continuity of care for those newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. CCHP ensures continuity of care for our Members who are currently receiving services from out-of-network providers, including pregnant Members. Medical care provided by an out-of-network provider for a pregnant Member will continue through the postpartum evaluation of the Member (up to six weeks after delivery). If a Member wants to change her OB/GYN to one who is in-network, CCHP allows her to do so if the provider to whom she wishes to transfer agrees to accept her in the last trimester. Services provided by out-of-network providers require prior authorization.

CCHP will reimburse a Member's existing out-of-network provider for ongoing care for no more than:

- Ninety days after a Member enrolls in CCHP, or
- More than nine months in the case of a Member who, at the time of enrollment in CCHP, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in CCHP.

CCHP provides or reimburses out-of-network providers who provide medically necessary covered services to Members who move out of the Service Area through the end of the period for which a premium has been paid for the Member.

Providers are encouraged to call the CCHP Care Management Department at 682-885-2252 or 1-800-862-2247 for assistance with any continuity of care/transition of care issues.

II PROVIDER RESPONSIBILITIES

PRE-EXISTING CONDITIONS

CCHP is responsible for ensuring access to all medically necessary covered services for each eligible CCHP Member beginning on the Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services.

REQUIRED MEDICAL RECORD DOCUMENTATION

The following is a list of standards that medical records must reflect all aspects of patient care, including ancillary services:

- Each page or electronic file in the record contains the member's name or ID number;
- Age, sex, address and phone number are recorded;
- All entries are dated and the author identified;
- The record is legible to someone other than the writer;
- Medication allergies and adverse reactions or the absence of same is recorded in a prominent location;
- Past medical history is recorded for all patients seen three or more times;
- Immunizations are recorded in a readily accessible location;
- Medication information is recorded in a consistent and readily accessible location;
- Current problems and active diagnoses are recorded in a consistent and readily accessible location;
- Member education regarding physical and/or behavioral health problems is documented;
- Notation concerning tobacco, alcohol and substance abuse and documentation of relevant member education is present on an age appropriate basis;
- Consultations, referrals and specialist reports are included;
- Emergency service is documented;
- Hospital discharge summaries are included;
- Evidence and results of screening for medical, preventive and behavioral health screening are present;
- Diagnostic information is appropriately recorded;
- Treatment provided and results of treatment are recorded;
- Documentation of the team members involved in the care of members requiring a multidisciplinary team; and
- Documentation in both the physical and behavioral health records showing appropriate integration of care.
- Documentation of individual encounters must provide adequate evidence of, at a minimum:
 - History and physical examination. Appropriate subjective and objective information is obtained for the presenting complaints.
 - For members receiving behavioral health treatment, documentation to include "at risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social history).

II PROVIDER RESPONSIBILITIES

- Admission or initial assessment includes current support systems or lack of support systems.
- For members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- Plan of treatment that includes activities/therapies and goals to be carried out.
- Diagnostic tests.
- Therapies and other prescribed regimens. For members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.
- Follow-up. Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals and results thereof;
- Consultation, lab and imaging reports noted to indicate review and follow-up plans by primary care provider;
- All other aspects of patient care, including ancillary services.
- For members 18 years of age and older, documentation of advance directives and/or mental health declaration, or indication of education.

CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN)

Cook Children's Health Plan offers enhanced care management for CSHCN. The CHIP enrollment process will identify Children with Special Health Needs. Primary Care and Specialty Care Providers should also notify the CCHP Care Management Department of covered members who may qualify for this program.

A child can be classified as a Child with Special Health Care Needs (CSHCN) if the answers to the following 5 questions can be answered 'yes.'

Does the child have a:

- Serious on-going illness?
- Complex on-going condition?
- Disability?

Is the illness, condition, or disability one that:

- Has lasted for at least 12 months in a row or more, or
- Is expected to last for at least twelve months in a row or more?

Does the child's illness, condition or disability cause (or without treatment, can it cause);

- Limits in the child's ability to function (activities such as walking, talking, running, eating, playing, learning or relating to others); and
- Are these limits not usual for most children his or her age?

II PROVIDER RESPONSIBILITIES

Does the child's illness, condition, or disability require regular, on-going treatment and review by doctors, therapists, or other trained health care professionals?

Does the child need health care or related services more often than most children do his or her age?

Early identification of children that may benefit from case management is an integral component of the program and begins at the time of enrollment. CCHP aggressively attempts to identify members that may benefit from case management services through use of the following: claims triggers; Health Needs Risk Assessment; utilization review activities; referrals from members, families, physicians and community agencies. When a member is designated as having CSHCN status, a Case Manager will contact the member's family to discuss covered services, the family's right to request a specialist as a primary care provider, out-of-network services applicable to the child's condition if not available in-network, the availability of enhanced care coordination, and referral to community programs or resources. In collaboration with the member, family, and the member's health care providers, the Case Manager develops a written plan of care that meets the member's health care needs. Referrals to community agencies when appropriate are included in the plan of care.

Designation of a Specialist as a PCP

A family with a child that has been designated to have CSHCN status or has chronic and/or complex health care need, has the right to request a specialist for a PCP. The child's PCP may also make this request. In order to accept such a request, the specialist must agree to provide all primary care services, (i.e. immunizations, well child care, coordination of all health care services required by the child). A case manager from the Care Management Department will notify a member's family of the right to request a specialist to be the PCP when CSHCN status is confirmed. In addition, the CSHCN's family may contact the Care Management Department to make this request. **The form to be used for approval of a Specialist to act as a PCP is located in the Forms section of this provider manual.**

III CARE MANAGEMENT

CARE MANAGEMENT

Cook Children's Health Plan's (CCHP) Care Management Program encompasses medical management (utilization management, case management, and disease management) and population management (predictive modeling, risk assessments/health screenings, preventive care reminders). The Care Management program leverages the integration of all program functions to deliver a "member-centric" model of care management. All department employees form teams comprised of Registered Nurse Case Managers, Social Workers, and Care Management Assistants (non-clinical) who focus on a population of CCHP membership.

UTILIZATION MANAGEMENT

Specialty Provider Referral

CCHP does not require notification to the health plan of in-network provider referrals. The provider is asked to document all referrals in the member's medical record. Member self-referral is not permitted. All out-of-network specialty provider referrals require documentation of medical necessity to be submitted for prior approval of the CCHP Medical Director. Member eligibility must be confirmed.

Members may self-refer for the following services:

Obstetrics & Gynecology - (OB/GYN) Services – Female members may self-refer to a participating OB/GYN or GYN specialist to obtain obstetrical or gynecological related care. CCHP members may also access their PCP for these services.

Behavioral Health Services – Members may access their mental health/substance abuse benefits by contacting the behavioral health provider indicated on the Member's ID card.

Emergency Services– Members are instructed to call their PCP as soon as possible after receiving emergency services. The PCP is not required to send notification to the Care Management Department

Observation Stays

Observation stays are limited to twenty-four hours or less.

Pregnancy Notification

Most pregnant CHIP members and their newborns, up to age one year, qualify for Medicaid. Since the Medicaid Program provides a more comprehensive scope of services (i.e., transportation assistance, etc) for both the pregnant member and her newborn, it is in the best interest of the pregnant member to receive Medicaid coverage as early as possible. For this reason, it is critical that providers notify CCHP immediately (within one business day) upon learning about a CHIP member's pregnancy.

CCHP will refer the member to the Medicaid Program to facilitate determination of Medicaid eligibility. Pregnant CHIP members who are Medicaid eligible will be transitioned from CHIP to Medicaid. On occasion, a pregnant member will not qualify

III CARE MANAGEMENT

for Medicaid or does not notify CCHP of her pregnancy. If this occurs, CCHP will cover the cost of the delivery; however, the provider must immediately (within one business day) notify CCHP.

Newborns are not automatically covered by CHIP. The CHIP member must apply for Medicaid coverage for her baby. If the newborn is determined to be eligible for Medicaid within three months of birth, the newborn's Medicaid eligibility will be retroactive to the baby's date of birth when there are unpaid medical bills for each of those three months. Newborns may be enrolled in CHIP if the mother/subscriber applies for CHIP.

Prior Authorization

Services requiring prior authorization must be reviewed by CCHP for medical necessity prior to the provision of services to the member. The following services require prior authorization:

- All out-of-network services
- Bariatric surgery
- Category III CPT Codes (CPT Codes for emerging technology, services, and procedures)
- Chiropractic treatment
***Initial evaluation visit does not require precertification*
- Durable medical equipment
***Not all DME requires prior authorization. Please see the CCHP website for a complete listing of DME requiring prior authorization or a list of the most current prior authorization requirements will be faxed to your office upon request to the Care Management Department.*
- Inpatient admissions (including acute, skilled nursing and rehabilitation facilities)
***CCHP Care Management must be notified of emergency admissions within one business day of admission.*
- Emergency treatment for dental trauma
- HOME health services (all services except PT/OT/ST)
***Medications given in the home require approval from the Vendor Drug Program.*
- Hospice
- Imaging
Positron Emission Tomography (PET)
Single Photon Emission Computed Tomography (SPECT)
- Infusions/Injectables (given in the office or clinic)
***Medications given in the home require approval from the Vendor Drug Program*
Includes: Botox, Synagis, Lupron, intravenous immunoglobulins (IVIG), Remicaid, biotech drugs.
Does Not Include: Immunizations, antibiotics, chemotherapy, allergy serum.
- Maternity – notification required after initial prenatal visit

III CARE MANAGEMENT

- Neuropsychological testing (*related to organic disease*)
- Non-emergency ambulance transport
- Orthognathic surgery
- Orthotics and prosthetics
***Not all orthotics and prosthetics require prior authorization. Please see the CCHP website for a complete listing of DME requiring prior authorization or a list of the most current prior authorization requirements will be faxed to your office upon request to the Care Management Department.*
- Outpatient/ambulatory surgery
***Not all outpatient surgeries require prior authorization. Please see the CCHP website for a complete listing of DME requiring prior authorization or a list of the most current prior authorization requirements will be faxed to your office upon request to the Care Management Department.*
- Plastic, Reconstructive or cosmetic procedures
- Radiation therapy
- Transplants

Included in the prior authorization process are:

- Verification of eligibility and benefits
- Determination of medical necessity
- Referral of a member to case or disease management programs when appropriate

Prior authorization is not a guarantee of payment. All services are subject to the plan provisions, limitations/exclusions, and member eligibility at the time the services are rendered. Services requiring require prior authorization are not eligible for reimbursement by CCHP if authorization is not obtained and cannot be billed to the member. The decision to render medical services lies with the member and the treating provider.

Prior Authorization Determinations

UM Case Managers process service requests in accordance with the **clinical** immediacy of the request.

If priority is not specified on the referral request, the request will default to routine status.

- Emergent – within one (1) hour of receipt of all the necessary information
- Urgent – within one (1) business day of receipt of all the necessary information
- Routine – within three (3) business days of receipt of all the necessary information

Medical Necessity Screening Criteria

InterQual® Criteria are utilized by non-physician reviewers (Registered Nurses) to determine medical necessity and appropriate level of care. In the event that InterQual® Criteria do not exist for proposed services, other resource guidelines (i.e., Texas Medicaid Providers Manual, internally developed criteria, etc) are used to determine medical necessity and appropriate level of care. Criteria utilized in the medical necessity review of a service request will be faxed to you upon request.

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Adverse Determinations

A denial is issued when medical necessity cannot be determined for a requested service. Only the CCHP Medical Director or physician designee can render an adverse determination. Prior to issuing an adverse determination, providers will be notified by telephone and/or fax of the pending denial and offered the opportunity to submit additional clinical information or to discuss the member's case with the Medical Director/designee. If you disagree with a Care Management decision, you have the right to access the CCHP Medical Necessity Appeal Process.

Administrative Denials

CCHP may issue administrative denials for the following:

- Non-covered benefit
- Insufficient information received to process the request
- Failure to obtain prior authorization in a timely manner.

If you disagree with an administrative denial, you have the right to file a complaint. The CCHP Complaint Process is detailed in Section V.

Reconsideration is a second review of a service request when additional information is received by CCHP. This level of review is not an element of the Appeal or Complaint Processes but provides a means of resolving an administrative or medical necessity denial without accessing the Complaint or Appeal Process. If the denial is upheld, the provider, member or member's representative may pursue the appropriate Complaint or Appeal Process.

Medical Necessity Appeals

CCHP maintains an internal appeal process for the resolution of medical necessity appeal requests. CCHP informs the member, the provider requesting the service, and the service provider of appeal rights, including how to access expedited and Independent Organization Review appeals processes at the time a service is denied. The member, the member's representative, or the member's health care provider may appeal an adverse determination (medical necessity denial) orally or in writing. Within five business days from receipt of an appeal, a letter acknowledging the date that the oral or written appeal was received is sent to the appellant. Included with the letter is a list of documents/information required to process the appeal. A one page appeal form is enclosed with the acknowledgment letter when the appeal request is oral. Standard appeals resolutions are resolved and communicated to the appellant no later than 30 calendar days from receipt of the appeal.

Specialty Review – Second Level Appeal

A second level of appeal is available to the physician or dentist requesting the denied service. The provider may request a specialty review in writing within ten business days of receipt of the first level appeal resolution upholding the denial. A provider in the same

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or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion and not involved in previous determinations will review the adverse determination. Specialty review is completed within fifteen business days of receipt of the appeal request.

Expedited Appeal Process

Investigation and resolution of appeals relating to presently occurring emergencies, care for life-threatening conditions, or denials of continued stays for hospitalization follow the Expedited Appeal Process. A provider not involved in previous determinations and in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion reviews the adverse determination and all related denial and appeal documentation. Investigation and resolution of expedited appeals are completed based on the medical or dental immediacy of the condition, procedure or treatment but does not exceed one business day from the date all information necessary to complete the appeal is received. The appeal resolution is communicated to the appellant via telephone and in writing.

Independent Review Organization Appeal

An Independent Review Organization (IRO) is an external organization that is selected by the Texas Department of Insurance (TDI) to review the request for appeal and render a decision on the request. An IRO appeal may be requested by the member, member's representative, or health care provider. Immediate access to an IRO review is available immediately for appeals relating to presently occurring emergencies, care for life-threatening conditions, or denials of continued stays for hospitalization without completion of the CCHP Medical Necessity Appeals Process. IRO Request Forms are included all adverse determination letters or can be obtained by calling the Care Management Department.

The IRO makes its determination no later than:

- The 15th day after the date the IRO receives the information necessary to make the determination; or
- The 20th day after the date the IRO receives the request that the determination be made; and
- In the case of a life-threatening condition, not later than the 5th day after the IRO received the information necessary to make the determination; or
- The 8th day after the date the IRO receives the request that the determination be made.

If you are not satisfied with the outcome of the CCHP Appeal Process, you can file a complaint with:

Texas Department of Insurance
Attention: Mail Code 103-6A
PO Box 149104
Austin, TX 78714-9104
Phone: 1-866-554-4926

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No Retaliation

CCHP will not retaliate against any person filing a complaint against CCHP or appealing a decision made by CCHP.

COMPREHENSIVE CASE MANAGEMENT PROGRAM

The Comprehensive Case Management Program (CCMP) provides enhanced care coordination services for members with catastrophic or chronic illnesses/injuries. A CCMP Case Manager performs a comprehensive case management evaluation to identify potential opportunities for case management intervention and develops an individualized plan of care to address identified needs in collaboration with the member/family and treating health care providers. The case manager monitors and evaluates the member's progress toward mutually agreed upon goals.

Members with any of the following diagnostic categories may benefit from this program. *(This is not a complete listing of those diagnostic categories appropriate for this program.)*

- Major trauma
 - Burns of 20% or more of the total body surface
 - Amputations
 - Spinal cord injuries
 - Traumatic brain injury
- Complex Medical Conditions
 - Malignancy
 - Blood Disorders
 - Neuromuscular disorders
 - Endocrine/Metabolic disorders
 - Renal failure/disease
 - Cerebral Palsy
 - Cystic Fibrosis
 - HIV+/AIDS
 - Cardiovascular disorders
- Psychosocial issues which are impacting the member's health
 - Non-compliance
 - Terminal diagnosis
 - Multiple hospitalizations
 - Extended home care needs
 - Mental Health co-morbidities

To refer a member to the CCMP, please call (682-885-2252 or 800-862-2247) or fax (682-885-8402) the Care Management Department. The case manager will notify PCPs of all members in their practice receiving case management services and will provide a copy of the member's case management plan of care along with periodic updates of plan of care when appropriate.

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DISEASE MANAGEMENT PROGRAMS

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which self-care efforts are significant.

Disease Management:

- support the provider/patient relationship and treatment plan,
- emphasizes prevention of exacerbations and complications through the use of evidence-based practice guidelines and patient empowerment strategies, and
- evaluates clinical, quality of life and economic outcomes with the goal of improving overall health.

CCHP Disease Management Programs

Currently CCHP offers disease management programs for members who have been diagnosed with asthma, diabetes (Type I and II), and pregnancy. Disease Management services are provided to members at no cost.

Levels of Disease Management

Based on the assessed severity of the member's symptoms, the member is assigned to either Level 1 or Level 2 of the Disease Management Program.

Level 1: Education level

Members less severe in symptoms or acuity are enrolled in the education level of the program. As part of the education level, members receive:

- A Disease Management Enrollment packet which includes:
 - Introduction letter notifying of enrollment into the disease management program.
 - Contact information, including phone numbers, days and hours a nurse case manager can be reached.
 - A description of resources and services available,
 - Disease specific educational materials in English and Spanish at 4th to 6th grade reading level.
- Information through CCHP outreach activities (i.e. mailings, member newsletters, media) such as Health Fairs and educational offerings they may attend.
- Monitoring of service utilization for potential Level 2 case management triggers

Level 2: Case Management

Members, who are higher in severity, as evidenced by poor symptom/disease control, or history of emergency room, urgent care or inpatient admissions, may be enrolled in Level 2 of the Disease Management program. Level 2 interventions include:

- A Registered Nurse Case Manager experienced in disease management performs a comprehensive case management evaluation, including psychosocial issues, medical diagnosis, services being received, identification of barriers to care.
- Physicians are provided feedback regarding member's severity level, educational needs, compliance issues, potential barriers and case management interventions.

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- Members and attending providers are sent a mutually agreed upon plan of care which is frequently reviewed and updated by the nurse case manager, depending on the members ongoing needs.
- Members are mailed a Disease Management Enrollment packet which includes:
 - an introduction letter which notifies of enrollment into the disease management program;
 - contact information, including phone numbers, days and hours a Case Manager can be reached;
 - a description of resources and services available;
 - disease specific educational materials in English and Spanish at 4th to 6th grade reading level.
- Members receive notification of CCHP outreach activities such as Health Fairs and educational offerings they may attend.
- Case Managers monitor medical, pharmacy claims data, and utilization management activities to determine a change in the member's disease severity/control.

Goals of Disease Management:

- Support the physician or practitioner/patient relationship and plan of care;
- Emphasize prevention of exacerbations and complications through environmental assessment and intervention, patient, family and physician/practitioner contact and educational reinforcement;
- Utilize evidence-based practice guidelines and patient empowerment strategies;
- Evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health; and,
- Provide feedback to physicians/practitioners regarding a patient's disease severity level, educational needs, compliance issues, potential barriers and disease management interventions.

Referrals

To refer a patient to the Asthma, Diabetes, or Maternity Disease Management Programs:

- Call 1-800-862-2247 to speak with a Disease Management Case Manager; or
- Fax a referral to 682-885-8402.

QUALITY MANAGEMENT PROGRAM (QMP)

The purpose of CCHP's QMP is to assure that attributes of care such as accessibility, quality, effectiveness and cost are measured in order to provide feedback to physicians, other providers and members so that CCHP can influence the quality of healthcare services provided to our members. The QMP also evaluates non-clinical services that influence member and provider satisfaction with CCHP.

The CCHP Quality Management Committee reviews the performance of the QMP at least quarterly, using performance data obtained from internal and external sources based on a reporting calendar. The scope of monitoring includes health plan performance, and clinical and service performance in institutional and non-institutional settings, primary care, and major specialty services including mental health care. The method and frequency of data collection are defined for each indicator. The integrity of the data is protected to ensure its validity, reliability, accuracy and confidentiality. Specific goals and data collection sources are standardized throughout the CCHP whenever possible and include, but are not limited to, the following areas:

- Continuous Quality Management Indicators: Certain important aspects of care are monitored on a continuous basis. Performance compared to standards approved by the QMC is reported back to the Committee on a periodic basis.
- Member Safety: Reduction or elimination of the possibility of adverse occurrences in order to maintain patient safety.
- Focused Studies: The QMC will conduct at least two focused studies each year that address clinical quality of care issues and one that addresses compliance with preventive health standards.
- Performance Improvement Projects: Initiatives designed to improve health plan performance compared to established benchmarks.
- Clinical Practice Guideline development, adoption, and annual review and update.
- Utilization management data showing trended referral rates, admission rates, length of stay and other pertinent aspects of utilization.
- Service Accessibility Assessments: Service accessibility is measured and compared to standards on a periodic basis.
- Drug and biological utilization data.
- Physician profiling reports.
- Reports by the Medical Director of personal visits with physicians whose practice patterns differ from the majority of physicians within their specialty, or with physicians who withdraw from participation in the CCHP.
- Quality of Care Occurrence Reports: Each report will be reviewed, tracked and trended for opportunities for improvement.
- Member Complaints, Grievances and Appeals: The QMC reviews detailed reporting of complaints and grievances with trended and summarized data.
- Member Satisfaction Surveys: Member satisfaction surveys will be conducted no less often than biannually by the EQRO with results reported to health plans for review and analysis. CCHP contracts with an external vendor,

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AVATAR, to conduct the CAHPS survey. Results are reported to CCHP annually and discussed at the QMC.

- Member Services Performance: Includes responsiveness to member calls and disenrollment rates.
- Medical record and office site visit reviews.
- Credentialing and Recredentialing: All contracted providers and entities providing direct Member care must be approved at the time of initial contracting and every three years.
- Provider satisfaction surveys: CCHP conducts an annual provider satisfaction survey, with results are reviewed by the QMC.
- Delegation audit reports.
- Results of Quality Management Improvement Plans (sometimes referred to as “corrective action plans”) imposed upon contracted entities.

PRACTICE GUIDELINES

CCHP relies on the use of evidence based clinical practice and medical necessity guidelines to evaluate the quality of care, and to identify opportunities for clinical improvement. These guidelines are adapted from national guidelines for practice. All are reviewed, modified if appropriate, and approved by participating providers and the CCHP Quality Improvement Committee, which is composed of primary care physicians and a variety of specialists.

Topic	Source	Link
PREVENTION		
Preventive Services for Adults	U.S. Preventive Services Task Force (USPSTF) as part of an initiative of the Agency for Healthcare Research and Quality, and the National Immunization Program (CDC)	<i>Guide to Clinical Preventive Services, Second Edition</i> http://www.ahrq.gov/clinic/cpsix.htm <i>Guide to Clinical Preventive Services, Third Edition: Periodic Updates</i> http://www.ahrq.gov/clinic/gcpspu.htm Recommended Adult Immunization Schedule by Vaccine and Age Group http://www.cdc.gov/nip
Preventive Services for Children	National Immunization Program (CDC), the National Vaccine Advisory Committee, AAP Committee on Practice and Ambulatory Medicine, and	Recommended Childhood and Adolescent Immunization Schedule http://www.cdc.gov/nip Recommendations for Preventive Health Care (RE9535) http://aappolicy.aappublications.org <i>Also:</i> Bright Futures website: http://brightfutures.aap.org 3 rd Edition Guidelines (<i>Free Download</i>) http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Poc

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Topic	Source	Link
	Cook Children's Health Care System Clinical Excellence Committee	ket Guide.html <i>or to purchase:</i> I. <i>BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS SET</i> AVAILABLE FOR PURCHASE AT: http://www.aap.org/bst/showdetl.cfm?&DID=15&Product_ID=3757&CatID=132
Perinatal Care	American College of Obstetricians and Gynecologists	<i>Guidelines for Perinatal Care, Fifth Edition</i> available for purchase at http://sales.acog.com/acb/stores/1/product1.cfm?SID=1&Product_ID=242
CARDIOVASCULAR HEALTH		
Prevention, Detection, Evaluation, and Treatment of High Blood Pressure	National Institutes of Health (NIH), and National Heart, Lung and Blood Institute	http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf
Detection, Evaluation and Treatment of High Blood Cholesterol in Adults	National Institutes of Health (NIH), and National Heart, Lung and Blood Institute	ATP III Guidelines: http://www.nhlbi.nih.gov/guidelines/cholesterol/index.htm Executive Summary http://www.nhlbi.nih.gov/guidelines/cholesterol/atp_iii.htm
Early Identification And Treatment Of Children With Hyperlipidemia	Cook Children's Health Care System Clinical Excellence Committee	http://intranet.cchcs ldap/SiteCollectionDocuments/Hyperlipidemia%20Clinical%20Guideline%20R02-07.pdf Copies available on request from CCHP
CHRONIC ILLNESS		
Diagnosis and Management of Asthma	National Institutes of Health (NIH), and National Heart, Lung and Blood Institute	Guidelines for the Diagnosis and Management of Asthma—Update on Selected Topics 2002 http://www.nhlbi.nih.gov/guidelines/asthma/index.htm
Managing Asthma During Pregnancy	National Institutes of Health (NIH), and National Heart, Lung and Blood Institute	Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment--Update 2004 http://www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.htm
Medical Care in Diabetes	American Diabetes Association	Standards of Medical Care in Diabetes http://care.diabetesjournals.org/cgi/content/full/28/suppl_1/s4
BEHAVIORAL HEALTH		

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Topic	Source	Link
Diagnosis and Management of Adults with Major Depression	Colorado Clinical Guidelines Collaborative	LifeSynch Clinical Guidelines for the Management of Depression http://www.lifesynch.com/products/quality.htm
Diagnosis, Evaluation and Treatment of ADD/ADHD	American Academy of Pediatrics	LifeSynch uses the National Attention Deficit Disorder Association guideline for ADHD. CorpHealth provider resource link: http://www.lifesynch.com/providers/resources.htm NADDA website: www.add.org PDF Guideline: http://www.add.org/pdf/GuidingPrinciples021206Rev[1].pdf
Treatment Recommendations for Patients With Bipolar Disorder	American Psychiatric Association	Practice Guideline For The Treatment Of Patients With Bipolar Disorder Copyright © 2002 American Psychiatric Association ALL RIGHTS RESERVED American Psychiatric Association 1000 Wilson Boulevard Arlington, VA 22209-3901 www.psych.org http://www.psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx
Health Literacy		
Recognizing and Responding to Health Literacy Problems of Adult and Pediatric Patients.	Various	<p>Agency for Healthcare Research & Quality : Literacy and Health Outcomes Summary: http://www.ahrq.gov/clinic/epeccsums/litsum.pdf Full Report: http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf</p> <p>American College of Physicians Foundation Website: http://www.foundation.acponline.org/index.htm Video: http://www.foundation.acponline.org/hl/hlvideo.htm</p> <p>American Medical Association Foundation: Website: http://www.ama-assn.org/ama/pub/category/8115.html Video: http://www.ama-assn.org/ama/pub/category/8035.html</p> <p>California Health Literacy Initiative: Website: http://cahealthliteracy.org/</p> <p>Harvard School of Public Health: Health Literacy Studies http://www.hsph.harvard.edu/healthliteracy/</p> <p>Health Resources & Services: Health Literacy http://www.hrsa.gov/healthliteracy/</p> <p>Institute for Healthcare Advancement: Health Education Literacy Program</p>

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Topic	Source	Link
		<p>http://www.iha4health.org/index.cfm/MenuItemID/125.htm</p> <p>Institute of Medicine: Health Literacy Related Resources & Links http://www.iom.edu/CMS/3775/3827/15441.aspx</p> <p>Institute of Medicine: Health Literacy: A Prescription to End Confusion http://www.iom.edu/?id=32784</p> <p>Joint Commission: Improving Health Literacy to Protect Patient Safety http://www.jointcommission.org/NewsRoom/PressKits/Health_Literacy/default.htm</p> <p>National Center for Education Statistics Website: http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006483</p> <p>National Institute for Literacy Website: http://www.nifl.gov/nifl/facts/health.html</p> <p>North Carolina Institute of Medicine: Just What Did the Doctor Order? : Addressing Low Health Literacy in North Carolina http://www.nciom.org/projects/health_literacy/literacy.html</p> <p>Office of Disease Prevention & Health Promotion: Quick Guide to Health Literacy http://www.health.gov/communication/literacy/quickguide/</p> <p>World Education Literacy and Health Initiative Website: http://healthliteracy.worlded.org/what-is-health-lit.htm</p>

Quality Improvement Focus Studies

CCHP is required to conduct at least two focus studies per year based on state requirements. CCHP utilizes national standards for the creation of focus studies for clinical and non-clinical services, cost and utilization, and effectiveness of care. Each year CCHP evaluates the effectiveness of its Quality Improvement Program based on standards for service and quality of care established by the National Committee for Quality Assurance (NCQA).

The following measures are Healthcare Effectiveness Data and Information Set (HEDIS) 2009 measures of quality of health care developed by the NCQA. In addition are

measures created internally to supplement HEDIS studies and are broken out in two groups, clinical and service studies.

Clinical

- Well-child visits in the first 15 months of life
- Well-child visits ages 3, 4, 5, and 6 years old
- Adolescent well-care visits
- Childhood Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children With Pharyngitis
- Correlation of Streptococcal Testing and Antibiotic use in Streptococcal Pharyngitis
- Chlamydia Screening in Women
- Comprehensive Diabetes Care
- Use of Appropriate Medications for People with Asthma
- Follow-up Care for Children Prescribed ADHD Medication
- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care
- Weeks of Pregnancy at Time of Enrollment in the MCO
- Annual Monitoring for Patients on Persistent Medications
- Relative Resource Use for People With Diabetes
- Relative Resource Use for People With Asthma
- ADHD Clinical Resource Guide Work group-CCHP and Corphealth

Service

- Provider Satisfaction
- Member Satisfaction
- Geographical Access Study
- Access and Availability Study
- Member Satisfaction through CAHPS
- Primary Care Access Study
- Behavioral Health Care Access Study
- Improving Medical Check-Up visits within 90 days of enrollment

Utilization Management Reporting Requirements

The primary responsibility for monitoring appropriate use of health services is vested with the Medical Director of CCHP. The Medical Director will establish UM requirements that may be revised from time-to-time to assure the delivery of quality care in a cost-effective manner. The Medical Director will be assisted by Case Managers who will act on behalf of the Medical Director in communicating with participating providers. Specific requirements for the process are as follows:

REVIEW PROCESS

The above goals are accomplished by three different review methods.

Prospective Review

A method for reviewing and authorizing elective procedures/tests, both inpatient and outpatient, to determine if the case meets established medical quality criteria, and is being provided in the most efficient and cost-effective manner.

Concurrent Review

A method of reviewing and authorizing current ongoing medical care to ensure that the level of care is appropriate, that the care meets established quality criteria, and that the care is being delivered in the most efficient and cost effective setting.

Retroactive Review

A method of reviewing medical care provided prior to the date of review to determine if care was provided in accordance with established medical quality criteria in the most appropriate and cost effective setting.

PROVIDER COMPLAINT AND APPEAL PROCESS TO CCHP AND TDI

For CHIP, Providers follow the same complaint process as described below for CHIP members.

MEMBER COMPLAINT AND APPEAL PROCESS**WHAT TO DO WHEN YOU HAVE A COMPLAINT**

What should I do if I have a complaint? Who do I call? CCHP wants all its members to be satisfied with their health care services. If at any time you are not satisfied, please call Member Services at **(682) 885-2247** or **(800) 964-2247**.

Can someone from Cook Children's Health Plan help me file a complaint? A Member Services Representative will help you file your complaint. You may also send your complaint in writing to CCHP. Mail your letter to:

Cook Children's Health Plan
P.O. Box 2488
Fort Worth, Texas 76113-2488
Attn: Complaint Department

How long will it take to process my complaint? CCHP will send you a letter within 5 working days telling you that we have received your complaint. If you called CCHP with your complaint, we will also include a complaint form with the letter.

What are the requirements and timeframes for resolving a complaint? Within 30 days of receiving your written complaint, CCHP will mail you a letter with the outcome of the complaint.

Do I have the right to meet with a complaint appeal panel? If you do not like the response to your complaint, you may contact CCHP and request an "appeal" by asking for a hearing with the Complaint Appeal Panel. This is a group of people that includes equal numbers of:

- community people who have CHIP;
- people who work on the CCHP team
- our Quality Management staff; and
- Healthcare providers.

WHAT CAN I DO IF CCHP DENIES OR LIMITS MY DOCTOR'S REQUEST FOR A COVERED SERVICE?

You may ask CCHP for another review of this decision.

PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION

How will I be notified if services are denied? If services are denied, CCHP will send your provider a letter explaining why the service was denied and will send you a copy of the letter.

What are the timeframes for the appeal process? All requests for an appeal shall be completed no later than 30 calendar days after CCHP receives your request unless your doctor feels a specialty review is necessary. The specialty review will be completed within 15 working days from the receipt of the request for an appeal. If CCHP does not approve an emergency service or longer stay in the hospital, the appeal must be finished in 1 working day.

When do I have the right to request an appeal? Does my request have to be in writing? You have the right to request an appeal as soon as you receive the letter telling you that the service was denied. You can request an appeal orally or in writing. Every oral appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

Can someone from Cook Children's Health Plan help me file an appeal? Yes. CCHP Case Managers can help you file an appeal.

EXPEDITED APPEAL (For emergency services denials and denials of continued hospital stays)

What is an expedited appeal? You can ask for an expedited appeal if taking the time for a standard appeal could cause further harm to your child's health or life or their ability to regain their normal function.

How do I request an expedited appeal? Does my request have to be in writing? Contact the CCHP Care Management Department at (682) 885-2252 or (800) 862-2247. You can request an expedited appeal orally or in writing.

What are the timeframes for an expedited appeal? An expedited appeal must be completed based on the medical or dental immediacy of the condition, procedure or treatment but may not exceed one working day from the date all information necessary to complete the appeal is received. You will be told, by telephone and in a letter, of the decision.

What happens if CCHP denies the request for an expedited appeal? If the request does not meet the expedited appeal criteria, the appeal request will follow the appeal process described above.

Who can assist me in filing an appeal? If you need assistance filing an appeal, call CCHP's Care Management Department at **(682)885-2252** or **(800) 862-2247** and a Case Manager can help you.

INDEPENDENT REVIEW ORGANIZATION (IRO)

What is an Independent Review Organization (IRO)? An Independent Review Organization (IRO) is an external organization that is selected by the Texas Department of Insurance (TDI) to review the request for appeal and render a decision on the request.

How do I request an IRO review? Contact CCHP's Care Management Department at **(682) 885-2252** or **(800) 862-2247**. CCHP will contact TDI and send them all material regarding the appeal. If CCHP denies a service because it was not medically necessary, a letter will be sent to you with a form you can fill out to ask for an IRO.

What are the timeframes for this process? The IRO will make its determination no later than:

- The 15th day after the date the IRO receives the information necessary to make the determination; or
- The 20th day after the date the IRO receives the request that the determination be made; and
- In the case of a life-threatening condition, not later than the 5th day after the IRO received the information necessary to make the determination; or
- The 8th day after the date the IRO receives the request that the determination be made.

FILING COMPLAINTS WITH TDI

If I am not satisfied with the outcome, who else can I contact? If CCHP cannot settle your concern, you can file a complaint with the Texas Department of Insurance. You can call them at 1-800-252-3439 or write to:

Texas Department of Insurance
PO Box 149091
Austin, TX 78714-9091.

No Retaliation Allowed

CCHP will not punish a child or other person for:

- filing a complaint against CCHP; or
- appealing a decision made by CCHP.

CCHP is required to comply with the complaint and appeal procedures as defined by the Texas Department of Insurance. The complete description of the complaint process is provided below.

LEVEL ONE COMPLAINT AND APPEAL PROCESS

If an inquiry is not resolved to the member's or provider's satisfaction, the inquiry is upgraded to the status of a Complaint.

1. When a written or oral Complaint is received, it is properly recorded in the Complaint database and assigned a Complaint tracking number.
2. An acknowledgment letter will be mailed to the complainant within five (5) business days of receipt of the oral or written complaint. If the Complaint is received orally, a one-page complaint form is included with the acknowledgment letter explaining that the Complaint form must be completed and returned to CCHP for prompt resolution. In the event of a quality of care issue, CCHP will investigate the complaint prior to receiving the written complaint. The Complaint database is updated to reflect the date the oral or written Complaint is received as well as the date the acknowledgment letter and Complaint form, if applicable, was mailed to the complainant.
3. The acknowledgment letter will reference the assigned Complaint tracking number and advise the complainant of CCHP's complaint process which includes their appeal rights and timeframes for resolution of the complaint.
4. Once the completed Complaint Form or written Complaint is received and the required information is documented in the Complaint database, the Complaint is forwarded to the appropriate department for review and handling. The department reviewing the Complaint will keep the Regulatory Compliance Analyst informed on the status of the review as the Complaint must be resolved within thirty (30) calendar days after CCHP receives the completed Complaint Form or the written Complaint.
5. Paragraphs 2 -4 do not apply to a complaint concerning an emergency or a denial of a continued hospitalization. CCHP shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical immediacy of the case and not later than one business day after CCHP receives the complaint.
6. The resolution letter must include an explanation of CCHP's resolution of the Complaint, a statement of the specific medical and contractual reasons for the resolution; and the specialization of any physician or other provider consulted. The resolution letter must also contain a full description of the process for Appeal, including the deadlines for the Appeals process and the deadlines for the final decision on the Appeal.
7. The entire process as outlined above, will be documented in the Complaints and Appeals database. Summary reports of all complaint activity are provided quarterly to the Quality Management Committee. Any and all documentation related to Complaints and Appeals may be reviewed by TDI during any HMO investigation.
8. In the event the complaint involves multiple areas of responsibility; if the denial is based on a benefit determination; or if a trend is identified with a particular provider, the Complaint will be brought to the CCHP Operations Committee for review and resolution.

SECOND LEVEL APPEAL (COMPLAINT APPEAL PANEL)

If you are not satisfied with the outcome of your complaint, you have the right to appeal the outcome of your complaint to a Complaint Appeal Panel. If the Complaint is not resolved to the satisfaction of the complainant the complainant has the right to appear before a Complaint Appeal Panel (CAP) where they normally receive health care or at another site agreed to by the complainant. The Regulatory Compliance Analyst will coordinate this process with the various personnel and departments involved within CCHP. The appeals process, defined below, must be completed not later than 30 calendar days after receipt of the written request for appeal.

1. Within five (5) business days of receipt of the complainant's written request for review by a CAP, an acknowledgment letter will be mailed to the complainant. The Regulatory Compliance Analyst will make every attempt to contact the complainant by telephone to verify the meeting date and location.
2. The Regulatory Compliance Analyst will work with the various departments within CCHP to insure that all requirements for the CAP are being met. A member of the panel must not have been previously involved in the disputed decision. The complaint appeal panel will be composed of equal numbers of:
 - CCHP staff,
 - physicians or other providers with experience in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination, and
 - enrollees (enrollees may not be employees of CCHP).
 - If specialty care is in dispute, the panel must include a specialist in the field of care related to the dispute.

The Regulatory Compliance Analyst will assist in preparing all documents that will be used in the review by the Complaint Appeal Panel.

3. Not later than the fifth (5) business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, CCHP will provide to the complainant or the complainant's designated representative:
 - any documentation to be presented to the panel by the CCHP staff;
 - the specialization of any physicians or providers consulted during the investigation; and
 - the name and affiliation of each CCHP representative on the panel.
4. The complainant or designated representative if the enrollee is a minor or disabled is entitled to:
 - appear in person before the CAP;
 - present alternative expert testimony; and
 - request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.
5. Appeals relating to ongoing emergencies or denials of continued stays for hospitalization will be completed in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after the request for appeal is received. At the request of the complainant, CCHP shall provide, in lieu of a CAP, a review by a specialist of the same or similar specialty as the

physician or provider who would typically manage the medical condition, procedure or treatment and who has not previously reviewed the case. The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide on the appeal. Initial notice of the decision may be delivered orally if followed by written notice not later than three days after the date of the decision.

6. The CAP will only serve in an advisory role to CCHP. CCHP will consider the findings of the CAP and render our final decision.
7. Notice of the final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice must also include the toll-free telephone number and the address of the Texas Department of Insurance.

VI BEHAVIORAL HEALTH

BEHAVIORAL HEALTH

Behavioral Health is defined as covered services for the treatment of mental, emotional, or chemical dependency disorders. Emergency Behavioral Health Condition is defined as any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing 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.

Members may access their mental health/substance abuse benefits by contacting the behavioral health organization indicated on the Member's ID card. Referral by the member's PCP is not required.

All providers shall provide covered services that are within the scope of provider's licensure and specialty to members within the CCHP service area. CCHP is required to ensure that providers meets all current and future Texas and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the CHIP program and shall cooperate with CCHP to enable it to monitor compliance with these requirements. Providers will implement appropriate safeguards to prevent the use of disclosure of a member's protected health information other than as provided for by this agreement.

Primary care providers shall provide all covered primary care services to Members. These services shall be within the scope of primary care services normally provided by primary care providers. Primary care providers are required to have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Primary care providers shall assess the medical needs of Members for referral to a specialist provider and provide referrals as needed. Primary care providers must coordinate a Member's care with specialist providers after referral. In situations where no participating specialist provider is available to provide the service, providers shall discuss and obtain prior authorization for the selection of an appropriate non-participating specialist with CCHP. Proper referrals are required for all covered specialist provider services

Coordination with Medical Services

PCPs and behavioral health care providers are responsible to actively coordinate and communicate continuity of care. Members often seek treatment in a primary care provider setting.

Medical and behavioral health services will be coordinated with the local mental health authority, if applicable.

VI BEHAVIORAL HEALTH

Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies:

- When the behavioral health provider obtains the member consent for information release the form is completed and sent to the collaborative provider in providing behavioral health care. **A copy of the Consent for Disclosure form is located in the Forms Section of this manual.**
- The behavioral health provider may use the release, as necessary, for the administration and provision of care.
- Behavioral health providers will note contacts and collaboration in the member's chart.
- Behavioral health providers will respond to a request for collaboration within one week or immediately, if an emergency is indicated.
- The behavioral health provider will send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to his/her PCP.
- CCHP and its network providers will maintain confidential and secure files.

Behavioral health providers are responsible for respecting a member's rights and responsibilities;

- Referring a member with known or suspected physical health problems or disorders to his PCP for evaluation and treatment;
- Maintaining access to medical care 24 hours per day, 7 days per week. Access includes regular office hours and availability of the provider or a covering provider by telephone outside of normal business hours, including weekends and holidays;
- Submitting initial and clinical summary reports to a member's PCP with the member's or the member's legal guardian's consent;
- Ensuring that a member receiving inpatient psychiatric services is scheduled for outpatient follow-up and/or continuing treatment prior to discharge;
- Assuring access to any member discharged from an inpatient setting to follow-up within seven (7) days of discharge in an outpatient setting;
- Contacting any member that misses an appointment within 24 hours to reschedule the appointment;
- Obtaining prior authorization on services requiring prior authorization;
- Verifying member eligibility at each time of service;
- Completing and submitting claim forms in accordance with the provider agreement and the Provider Manual.
- Participating in CCHP and LifeSynch quality improvement and utilization management activities.

Behavioral Health Covered Services

Inpatient Mental Health Services:

Mental health services, including serious mental illness, furnished in a freestanding psychiatric hospital, psychiatric units of general acute hospitals and state-operated facilities, subject to the following:

- Inpatient mental health services do not require a PCP referral.

VI BEHAVIORAL HEALTH

- Neuropsychological and psychological testing are included.
- Inpatient mental health services are limited to:
 - 45 days per 12-month inpatient limit.
 - Includes inpatient psychiatric services, up to 12-month period limit, 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. Court ordered services are binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
 - 25 days of inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24 hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem costs.
 - 20 of the inpatient days must be held in reserve for inpatient use only.

Outpatient Mental Health Services:

Mental health services, including serious mental illness, provided on an outpatient basis, are subject to the following:

- Medication management visits do not count against the outpatient visit limit.
- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
- Up to 60 days per 12-month period limit for rehabilitative day treatment.
- 60 outpatient visits per 12-month period limit.
- 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost.
- 60 outpatient visits can be converted to skills training (psycho-educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost.
- Includes outpatient psychiatric services, up to 12 month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 if the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits.
- A Qualified Mental Health Professional (“QMHP”), as defined by and credentialed through Texas Department of State Health Services (“DSHS”) standards (TAC Title 25, Part II Chapter 412) is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHP’s are acceptable providers as long as the services would be within the

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scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

- Outpatient mental health services do not require a PCP Referral.

Inpatient Substance Abuse Treatment Services:

Inpatient substance abuse treatment services subject to the following:

- Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.
- Inpatient and residential substance abuse treatment services do not require a PCP referral.
- Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period.
- 24 –hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period.
- 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost.
- 30 days must be held in reserve for inpatient use only.

Outpatient Substance Abuse Treatment Services:

Outpatient substance abuse treatment services are subject to the following:

- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.
- Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skill straining which 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.
- Outpatient treatment services up to a maximum of:
 - Intensive outpatient program (up to six-months per 12-month period)
 - Outpatient services (up to six-months per 12-month period)
- Outpatient substance abuse treatment services do not require a PCP referral.

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Quality and Utilization Review Data Requested by Payor

Behavioral health provider contracted with CCHP will provide behavioral health services subject to the following:

- to provide covered members all medically necessary behavioral health services as defined by HHSC;
- to use the DSM-IV multi-axial classification when assessing covered members and any other assessment/instrument outcome measures required by HHSC;
- to document DSM-IV and assessment/outcome information in the covered member's medical record;
- to maintain screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
- to schedule for outpatient follow-up and/or continuing treatment for all covered members receiving inpatient psychiatric services, prior to discharge. The outpatient treatment must occur seven (7) days from the date of discharge;
- to contact covered members who have missed appointments within twenty-four (24) hours to reschedule appointments;
- to comply with 28 *Texas Administrative Code* Part 1, Chapter 3, Subchapter HH, as amended from time to time regarding Chemical Dependency Treatment; to provide inpatient psychiatric services to Covered Members under the age of 21, up to the annual limit under HHSC regulations, who have been ordered to receive BH Services by an authorized court; and
- to maintain at all times status as a Texas Medicaid program participating provider.

Court-Ordered Commitments

CCHP will make available inpatient and outpatient psychiatric services to CHIP members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provision of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities or placement as a condition of probation is authorized as by the TFC (Texas Family Code). CCHP will not deny, reduce or controvert the medical necessity of any court-ordered inpatient or outpatient psychiatric service. Any modification or termination of services will be presented to the court with jurisdiction over the matter for determination. A member who has been ordered to receive treatment under the provisions of the Texas Health and Safety Code cannot appeal the commitment through CCHP's complaint or appeals process. CCHP will comply with utilization review of chemical dependency treatment. Chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.

Coordination with Local Mental Health Authority

Early Childhood Intervention Services - Provider shall arrange for all medically necessary Covered services contained in the Member's Individual Family Service Plan ("IFSP") for members eligible for early childhood intervention services in the amount, duration and scope established by the IFSP. Medical necessity for health and behavioral

VI BEHAVIORAL HEALTH

health care services is determined by the interdisciplinary team as approved by the Member's primary care provider. CCHP must allow services to be provided by a non-network provider if a Participating Provider is not available who can provide the services in the amount, duration, scope and service setting as required by the IFSP. CCHP cannot modify the plan of care or alter the amount, duration, scope or service setting of services required by the Member's IFSP. CCHP cannot create unnecessary barriers for the Member to obtain IFSP services, including requiring prior authorization for the ECI assessment and insufficient prior authorization periods for prior authorized services.

Behavioral Health Quality Improvement Studies

Formal quality improvement studies for behavioral health are designed with input from a multi-disciplinary team/committee to ensure valid findings. As a further behavioral health resource, a psychiatrist is a member of the Medical Management Committee. Data is collected from an administrative database, medical record reviews, surveys and office site visits. Clinical and preventive service studies will in most instances be based on measurement against clinical guidelines.

In additions, both clinical and service indicators will be trended and reported. Performance Improvement Projects (PIP) such as HEDIS Follow-Up After Hospitalization for Mental Illness will be conducted on an annual basis. The findings from these reviews will be communicated to providers, as applicable. Questions may be directed to CCHP Quality Management Department at 1-800-862-2247.

Programmatic success is dependent upon the development of a strong neighborhood provider, hospital and ancillary provider network that actively interacts with behavioral health providers to meet the needs of the CCHP members. Through both formal and informal interaction with providers on the results of studies, provider data sharing, availability of resource information and timely feedback on areas for improvement, CCHP will provide support to assist providers in delivering the highest quality of care and service to members in the most satisfaction surveys, complaints, grievances, and feedback from the Community/Member Advisory Committee. CCHP has the opportunity to meet and exceed the needs of the communities that it serves.

Screening For Depression

Documentation in the medical record is required to demonstrating the use of a nationally recognized standardized screening instrument AND the outcome of the screen. Although it is expected the instrument will be used most frequently in Primary Care, it is accepted if the standardized instrument is used in another clinic. Approved screening instruments include:

- PRIME-MD (2 question screen used by Whooley & colleagues);
- MOS Depression items (recommended for patients under age 60);
- CEB-D (5 item brief version developed as screening instrument for patients age 60 and over)
- SSDS-PC
- CESD (5, 10, or 20 item version)

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- BDI-S (13 item version)
- BDI (21 items)
- Hamilton Rating Scale for Depression
- DSM4 criteria for MDD
- Williams et al one-item screener

A standardized instrument must be used. The name and a copy of the specific instrument needs to be made available to the EPRP abstractor. Selecting questions from different standardized instruments and creating a 'new' tool is NOT acceptable. Any instrument not included in the list below needs to be discussed with the Office of Quality and Performance.

Some facilities utilize a 2-step screening process; a first brief screen such as PRIME MD, then if positive a tool with more sensitivity (e.g. Beck Depression).

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Depression screening tools are available on the following websites:

Assessments.com has a large selection:	http://www.assessments.com/default.asp
Children's Depression Inventory (CDI)	http://www.cps.nova.edu/~cphelp/CDI.html
Available on the Lexapro website and developed by A John Rush, MD.	http://www.lexapro.com/english/understanding_depression/screener.aspx??PlacementGUID=68067DB2-32CB-4592-A105-1EA5D457F851
Available tools that can be opened and saved	http://projects.ipro.org/index/ami_ktools
Zung Self-rating Depression Scale	http://www.fhma.com/documents/zung.pdf
University of Michigan screen	https://www.mentalhealthscreening.org/screening/welcome.asp
Beck Depression Inventory II (BDI-II)	http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=164&page_id=6433792&query=Beck%2A&hiword=Beck%2A
Hamilton Depression Rating Scale (HAM-D)	http://healthnet.umassmed.edu/mhealth/HAMD.pdf
MOS depression items for patients under age 60	http://www.rand.org/health/surveys/core/mos.shortform.pdf
Center for Epidemiologic Studies Depression Scale (CES-D)	http://www.chcr.brown.edu/pcoc/cesdscale.pdf
CES-D available to use without permission	http://patienteducation.stanford.edu/research/cesd10.pdf

VIII BILLING

WHERE TO SEND CLAIMS/ENCOUNTER DATA

Paper Claims Address:

Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX 76161-1295

Electronic Claims Address:

CCHP Payer ID: CCHP1
Receiver Type Code: F

Appeals and COB Address:

Cook Children's Health Plan
P.O. Box 2488
Fort Worth, TX 76113-2488

FORMS TO USE

All services should be submitted to CCHP using a HCFA 1500 form or a UB-04 form.

EMERGENCY SERVICES CLAIMS

Emergency Services – CCHP pays for emergency service in and out of the area. Emergency service is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

The provider should direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition exists. If an emergency condition does not exist, the provider should direct the member to come to the office. CCHP does not require that the member receive approval from the health plan or the PCP prior to accessing emergency services. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency services. Providers are not required to notify CCHP Care Management about emergency services.

If CCHP receives a request for authorization of post-stabilization treatment, CCHP must respond to the emergent/urgent facility within one (1) hour. If the facility does not receive a response within one (1) hour, the post-stabilization services shall be considered authorized in accordance with Texas Department of Insurance statutes. The provider shall notify CCHP of all post-stabilization treatment requests.

VIII BILLING

BILLING MEMBERS

CCHP reimburses from the CCHP fee schedule. CCHP providers have agreed to accept the reimbursement as payment in full for services rendered to CCHP members.

If a provider furnishes services to a CHIP member that are not covered, including services that are not medically necessary, he or she must obtain the member's signature on a Patient Acknowledgement Form which informs the member of his or her financial responsibility. The Patient Acknowledgement Form is included in the Provider Responsibilities section of the manual.

Providers are allowed to bill members if retroactive eligibility is not granted. If the member does become retroactively eligible, the member should notify the provider of his or her change in status. Ultimately, the provider is responsible for timely filing of CHIP claims. If the member becomes eligible, the provider must refund any money paid by the client when a CHIP claim is filed.

As stated in the HHSC rules, providers are not allowed to bill CHIP members for claims denied or not received by CCHP due to provider error. Examples include not filing within the claims submission deadline, filing an incomplete or incorrect claim, or the provider's failure to submit a claim.

TIME LIMIT FOR SUBMISSION OF CLAIMS/ENCOUNTER DATE/CLAIMS APPEALS

CHIP claims and encounters must be filed no later than ninety-five (95) days following the date of service using a standard HCFA 1500 form or a UB-04 form. Claim appeals and corrective adjustments for CHIP members must be requested within 120 days of the claims processing date to be eligible for payment.

When appealing a claim that denied due to "timely filing limits," it is necessary to attach "proof of timely filing" in the form of a health plan explanation of benefits statement or other health plan correspondence. CCHP needs documentation from the Clearing House or proof of mailing as timely filing documentation.

CLAIMS PAYMENT

All Provider claims that are clean and payable must be paid within thirty (30) days from the date of claim receipt.

Claims that are clean and not payable must be denied within thirty (30) days from the date of claim receipt.

CCHP must notify the Provider in writing that the Provider has one hundred and twenty (120) days from the date of disposition to appeal a denied claim.

VIII BILLING

SPECIAL BILLING

The following value added services require special billing as follows:

- School Physicals do not need to be given by the member's primary care physician. The provider should bill CCHP using diagnosis code: V70.3.
- Increased Frame Allowance and Vision Services – claims for these services should be filed directly to Opticare and questions on how to file these claims should be directed to Opticare at 1-800-465-6853.
- Prepared childbirth classes are billed to CCHP listing the member's CHIP ID#, name, classes taken and billed amount. This should be sent to Cook Children's Health Plan, PO Box 2488, Fort Worth, TX 76113-2488.

CLAIMS QUESTIONS/APPEALS

To inquire about reimbursement or to resolve an error when payment of the claim is CCHP's responsibility, please call CCHP Claims Department at 1-800-964-2247. CCHP claim staff will review up to two (2) claims per phone call. If you have more than two (2) claims, please fax them to 682/885-2148 attention "Claims". CCHP will return the fax within (1) business day.

When calling or faxing CCHP please be prepared to provide the following information:

- Member ID Number
- Member Name
- Provider's Name
- Dates of Service
- Amount of the Claim
- Reason for Inquiring

Providers can view claims status at: www.cookchildrenshealthplan.org. If not registered to view this site, please see the forms section of this manual for registration information.

CLAIM FILING TIPS

- Always be sure to verify member eligibility prior to providing services.
- All claims must be filed within ninety-five (95) days of the date of service.
- A separate claim must be completed for each member and each provider.
- Always use the correct 2-digit place of service code.
- The prior authorization number must be on the claim, if applicable.
- Always provide the correct provider identification number such as UPIN, CCHP Provider Number or Tax ID (for ancillary providers) and the NPI#.
- When billing for inpatient services, be sure to list each inpatient day as a separate line item.

VIII BILLING

Cost Sharing Schedule

Benefit Plan	CCPN	CCHP	CCP1	CCP2	CCP3
FPL (Federal Poverty Level)	Cost Share Met/Native American	At or Below 100%	101%> - 150%	151% - 185%	186% - 200%
Enrollment Fee	\$0	\$0	\$0	\$35	\$50
Maximum out of pocket/cost sharing limit	\$0	1.25% of family income	1.25% of family income	2.5% of family income	2.5% of family income
Inpatient Hospital Services	\$0	\$10 per admission	\$25 per admission	\$50 per admission	\$100 per admission
Office Visit- Sick Child	\$0	\$3	\$5	\$7	\$10
Physician Services: - Well child, immunizations	\$0	\$0	\$0	\$0	\$0
Non-Emergency ER	\$0	\$3	\$5	\$50	\$50
Generic Drug	\$0	\$0	\$0	\$5	\$5
Brand Drug	\$0	\$3	\$5	\$20	\$20

VIII BILLING

	30 days per 12 month period	30 days per 12 month period	30 days per 12 month period	30 days per 12 month period	30 days per 12 month period
Outpatient Mental Health	\$0 30 visits per 12 month period	\$3 copay per visit 30 visits per 12 month period	\$5 copay per visit 30 visits per 12 month period	\$7 copay per visit 30 visits per 12 month period	\$10 copay per visit 30 visits per 12 month period
Inpatient Chemical Dependency	\$0	\$10 per admission	\$25 per admission	\$50 per admission	\$100 per admission
Outpatient Chemical Dependence	\$0 30 visits per 12 month period	\$3 30 visits per 12 month period	\$5 30 visits per 12 month period	\$7 30 visits per 12 month period	\$10 30 visits per 12 month period
Home Health Services	\$0	\$0	\$0	\$0	\$0
DME	\$10,000 per enrollment period	\$10,000 per enrollment period	\$10,000 per enrollment period	\$10,000 per enrollment period	\$10,000 per enrollment period
- Eyeglasses	\$0	\$0	\$0	\$0	\$0
- Hearing Aids	\$0	\$0	\$0	\$0	\$0
- Prosthetics	\$0	\$0	\$0	\$0	\$0
- DME	\$0	\$0	\$0	\$0	\$0

VIII BILLING

Prescription drugs open formulary per 30-day supply	\$0 Generic \$0 Brand	\$0 Generic \$3 Brand	\$0 Generic \$5 Brand	\$5 Generic \$20 Brand	\$5 Generic \$20 Brand
Outpatient Rehabilitation	\$0	\$0	\$0	\$0	\$0
Ambulance	\$0	\$0	\$0	\$0	\$0
Emergency Services	\$0	\$3	\$5	\$50	\$50
Pregnancy Physician (First Visit has copay / Additional prenatal visits are \$0 copay)	\$0	\$3	\$5	\$7	\$10
Inpatient	\$0	\$10 per admission	\$25 per admission	\$50 per admission	\$100 per admission
Transplants	\$0	\$0	\$0	\$0	\$0

VII COVERED SERVICES

CCHP participates in the CHIP program as a primary HMO through the CCHP product. There is no spell of illness limitation for CCHP CHIP members. At a minimum, the CCHP must provide a benefit package to Members that includes the following services:

INPATIENT GENERAL ACUTE AND INPATIENT REHABILITATION HOSPITAL SERVICES

Covered Services :

Medically necessary services include, but are not limited to, the following:

- Hospital-provided physician or provider services
- Semi-private room and board (or private if medically necessary as certified by attending)
- General nursing care
- Specialty duty nursing when medically necessary
- ICU and services
- Patient meals and special diets
- Operating, recovery and other treatment rooms
- Anesthesia and administration (facility technical component)
- Surgical dressings, trays, casts, splints
- Drugs, medications and biologicals
- Blood or blood products not provided 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)
- 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 for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
- Hospital, physician and related medical services, such as anesthesia, associated with dental care
- Surgical implants
- Other artificial aids including surgical implants
- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit

VII COVERED SERVICES

SKILLED NURSING FACILITIES (INCLUDES REHABILITATION HOSPITALS)

Services include, but are not limited to, the following:

- Semi-private room and board
- Regular nursing services
- Rehabilitation services
- Medical supplies and use of appliances and equipment furnished by the facility

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, a 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 provided 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 provided in a licensed ambulatory surgical facility
- Surgical implants
- Other artificial aids including surgical implants
- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit

PHYSICIAN/PHYSICIAN EXTENDER PROFESSIONAL SERVICES

Services include, but are not limited to, the following:

- American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
- Physician office visits, in-patient and outpatient services

VII COVERED SERVICES

- Laboratory, x-rays, imaging and pathology services including technical component and/or professional interpretation
- Medications, biologicals and materials administered in Physician's office
- Allergy testing serum and injections
- Professional component (in/outpatient) of surgical services, including:
 - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
 - Administration of anesthesia by physician (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 physician services (including Physician-performed technical and interpretative components)
- In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.
- Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.

DURABLE MEDICAL EQUIPMENT(DME), PROSTHETIC DEVICES AND DISPOSABLE MEDICAL SUPPLIES

\$20,000 12-month period limit for DME. Prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (Equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury or Disability, and is appropriate for use in the home), including services and supplies that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition, including, but not limited to:

- Orthotic braces and orthotics
- Prosthetic devices such as artificial eyes, limbs and braces
- Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease
- Hearing aids
- Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements

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 (R.N., L.V.N.,)
- Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).

VII COVERED SERVICES

- Home health aide when included as part of a plan of care during a period that skilled visits have been approved
- Speech, physical and occupational therapies
- Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker
- Skilled nursing visits are provided on an intermittent level and not intended to provide 24-hour skilled nursing services
- Services are not intended to replace 24-hour inpatient or skilled nursing facility services

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
- Inpatient mental health services are limited to:
 - 45 days 12-month period inpatient limit
 - Includes inpatient psychiatric services, up to 12-month period limit, 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. 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.
 - 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or subacute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost.
 - 20 of the inpatient days must be held in reserve for inpatient use only
 - Does not require a PCP referral

OUTPATIENT MENTAL HEALTH SERVICES

Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited:

- Medication Management visits do not count against the outpatient visit limit.
- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility
- Up to 60 days 12-month period limit for rehabilitative day treatment
- 60 outpatient visits 12-month period limit
- 60 rehabilitative day treatments days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost
- 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost

VII COVERED SERVICES

- Includes outpatient psychiatric services, up to 12-month period limit, 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. 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.
- Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits.
- A Qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services(DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHP's are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHP's. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.
- Does not require a PCP referral

INPATIENT SUBSTANCE ABUSE TREATMENT SERVICES

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
- Does not require PCP referral
- Medically necessary inpatient detoxification/stabilization services, limited to 14 days per 12-month period.
- 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period
- 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost
- 30 days must be held in reserve for inpatient use only.

OUTPATIENT SUBSTANCE ABUSE TREATMENT SERVICES

Services include, but are not limited to

- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.
- Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day

VII COVERED SERVICES

- 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
 - 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)
- **Does not require a PCP referral

REHABILITATION SERVICES

Services include, but are not limited to:

**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

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 for unrelated conditions is unaffected
- Up to a maximum of 120 days with a 6-month life expectancy
- Patients electing hospice services waive their rights to treatment related to their terminal illness; however, they may cancel this election at anytime
- Services apply to the hospice diagnosis

EMERGENCY SERVICES INCLUDING EMERGENCY HOSPITALS, PHYSICIANS, AND AMBULANCE SERVICES

CCHP cannot require prior authorization as a condition for payment for emergency conditions or labor and delivery.

Covered services include but are not limited to, the following:

- Emergency services based on prudent lay person definition of emergency health condition
- Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers
- Medical screening examination
- Stabilization services
- Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services
- Emergency ground, air or water transportation

VII COVERED SERVICES

- Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.

TRANSPLANTS

Services include, but are not limited to, the following:

- 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

VISION BENEFIT

The healthplan may reasonably limit the cost of the frames/lenses.

Services include:

- One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization
- One pair of non-prosthetic eyewear per 12-month period

CHIROPRACTIC SERVICES

Services do not require physician prescription and are limited to spinal subluxation

TOBACCO CESSATION PROGRAMS

Covered up to \$100 for a 12-month period limit for a plan-approved program

- Health Plan defines plan-approved program
- May be subject to formulary requirement

DENTAL SERVICES –COVERED THROUGH DELTA DENTAL

The Texas CHIP Dental Services Program offers three (3) tiers of coverage with expanded benefits as an incentive for timely renewal and payment of member enrollments fees. The tier level is based on the number of years of member eligibility: new members are eligible for Tier 1, members are eligible for Tier II upon the second year of coverage and Tier III upon the third year of coverage. Preventive services are subject to an annual maximum of \$250. The benefit levels in each Tier are:

Tier I Coverage:

- Preventative Services & Therapeutic Services up to \$285 of annual therapeutic services

VII COVERED SERVICES

Tier II Coverage:

- Preventative Services & Therapeutic Services up to \$425 of annual therapeutic services

Tier III Coverage:

- Preventative Services & Therapeutic Services up to \$565 of annual therapeutic services

EXCLUSIONS

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, 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 articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which 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, unless otherwise pre-authorized by Health Plan
- 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 physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
- Services, supplies, meal replacements or supplements provided 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
- 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)

VII COVERED SERVICES

- 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 assists a child 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 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 provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which 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 Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

IX FORMS

1. CCHP FORMS

CCHP On-Line Eligibility and Claims Status Registration Form

CCHP Prior Authorization Form

CCHP Pregnancy Notification

CCHP Delivery Notification

CCHP Specialist acting as a PCP Form

CCHP Consent for Disclosure

**ONLINE ELIGIBILITY AND CLAIMS STATUS
REGISTRATION FORM**

**Please fax back to: 682-885-8403
ATTN: Network Development**

- Please create a generic User ID: _____
- Please create a password: _____

CLINIC NAME: _____ **TAX ID:** _____

Provider's Name:	Phone #	Provider's E-mail Address:

Full Name of Staff Member(s) Requesting Access	Phone #	E-mail Address or Fax# if E-mail not available

If you have any questions, please contact Network Development at 682-885-2247.

**COOK CHILDREN'S HEALTH PLAN
Prior Authorization Request Form**

Care Management: 1-800-862-2247
Care Management Fax: 682-885-8402
Web Site: cookchp.com

Date Requested: _____
Type of Request: Routine Urgent Expedited Retro

SECTION 1: MEMBER/COVERAGE DATA

Name _____ DOB _____
ID# _____ PCP _____
Diagnosis _____ ICD-9 Code(s) _____

SECTION 2: PROVIDER DATA

A. REQUESTING PROVIDER

UPIN#(CHIP) _____ TPI#(STAR) _____ NPI#(CHIP/STAR) _____
Contact Name _____ Phone# _____ Fax# _____

B. SERVICE PROVIDER/FACILITY

Specialty _____
UPIN#(CHIP) _____ TPI#(STAR) _____ NPI# _____ Tax ID#(Facility) _____
Contact Name _____ Phone# _____ Fax# _____
Date of Service _____ Consult Only Visits # Requested _____ In-Network Yes No

SECTION 3: REQUESTED SERVICE(S): *** All Out of Network Services Require CCHP Approval Before Services Are Provided***

Procedure/Service(s): _____ CPT Code(s): _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Ambulance – air | <input type="checkbox"/> Ambulance - ground | <input type="checkbox"/> Office Procedures |
| <input type="checkbox"/> Assistant Surgeon/RNFA Name: _____ | | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Dental Anesthesia/Facility | | <input type="checkbox"/> Outpatient Surgery |
| <input type="checkbox"/> Diagnostic Tests | | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Dialysis | | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Durable Medical Equipment | | <input type="checkbox"/> Therapies: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST |
| <input type="checkbox"/> Home Health | | Visits/Frequency _____ |
| <input type="checkbox"/> Injectables/Infusion Services | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Inpatient _____ (Date) | | |
| <input type="checkbox"/> Observation _____ (Date) | | |

CLINICAL INFORMATION/ HISTORY/COMMENTS: [Attach Clinical Notes, Test Results, etc.]

SECTION 4: Approved Modified Approval [see attached letter] Denied [see attached letter]

Reference#/Units*/From-To:

THE ABOVE REFERENCE NUMBER DOES NOT GUARANTEE PAYMENT OF CLAIMS. PAYMENT OF CLAIMS IS SUBJECT TO THE MEMBER'S ELIGIBILITY AND TO THE CONTRACTUAL LIMITATIONS, PROVISIONS, AND EXCLUSIONS OF THE MEMBER'S BENEFIT PLAN.

COOK CHILDREN'S HEALTH PLAN PRIOR AUTHORIZATION REQUEST FORM COMPLETION GUIDE

❖ ****Note: Completely filled in information assists in the quick processing of your authorization request and claims.****

➤ **CCHP PRIOR AUTHORIZATION REQUEST FORM –**

- Enter date authorization is requested
- Check type of request [**based on medical need, not appointment time**].

➤ **SECTION 1: MEMBER/COVERAGE DATA – Enter:**

- member/patient name
- date of birth
- ID Number
- PCP [Primary Care Physician/Provider]
- Diagnosis and/or ICD-9 code(s).

➤ **SECTION 2: PROVIDER REQUESTING SERVICE; PROVIDER/FACILITY PROVIDING REQUESTED SERVICES – Enter:**

- *requesting provider's name [referred from]*
- check PCP or specialist [if specialist]
- provider's specialty
- contact person's name, phone and fax numbers
- *service provider's name [referred to] [enter "same" or leave blank if same as requesting provider]*
- specialty [if specialist]
- phone and fax numbers
- check the in network box yes or no
- *facility or ancillary provider name [referred to place of service]*
- date of service
- check the in network box yes or no
- check the consult only box or number of visits requested box [enter the number of visits requested].

➤ **SECTION 3: SERVICE INFORMATION – Enter:**

- procedure(s) and/or service(s) requested and CPT code(s)
- check box(es) for service(s) you are requesting
- enter and/or attach clinical information, history, comments.

✓ **SURGERY:**

- enter Assistant Surgeon, RNFA name [If not on "Procedures Allowing Assistant Surgeons, RNFA" guidelines list]
- enter Medical Necessity reason for Assistant Surgeon
enter names of surgeon and facility, etc [as listed above under SECTION 2]
- enter/attach clinical information.

✓ **THERAPIES:**

- check box(es) for therapy service(s) you are requesting
- enter name(s) of therapy/service(s) on Procedure/Service line and/or CPT code(s)
- enter number of visits, frequency and duration of therapy/service(s) on Procedure/Service line
- enter/attach clinical information.

➤ **SECTION 4: AUTHORIZATION RESPONSE – To be filled out by CCHP Care Management.**

❖ ****Note: Completely filled in information assists in the quick processing of your authorization request and claims.****

Pregnancy Notification

Complete this form, print and fax to 682-885-8402 at the time of pregnancy diagnosis.

Use the CCHP Prior Authorization Request Form for authorization if your pregnant patient requires a hospital or observation stay without delivery, or an out of network referral.

Baby Steps Program 1-800-862-2247; Fax 682-885-8402.

OB Name: _____

OB Phone #: _____ OB Fax #: _____

OB Office Contact: _____ Perinatologist Office Contact _____

Perinatologist: _____ Perinatologist Phone/Fax _____

Expected Delivery Facility: _____

MEMBER NAME: _____ DOB: _____

ID#: _____ MEMBER PHONE #: _____

EDC (Due Date): _____ LMP: _____ G: _____ P: _____

Other Health Insurance?: Yes No If yes, Insurance Name: _____

Risk Factors/Problems: _____

Medications: NONE Yes [If Yes, list]: _____

COOK CHILDREN'S HEALTH PLAN



Delivery Notification



Please complete this form for authorization by call or fax if your pregnant patient requires a hospital stay for delivery or a hospital stay without delivery; or if baby went to NICU.

Call: (682)885-2252 or (800)862-2247; Fax (682)885-8402

Member Name:	DOB:
Member ID #:	<input type="checkbox"/> CHIP <input type="checkbox"/> Medicaid/STAR
Other Health Insurance?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Insurance Name:
OB Name:	Delivery Facility:
OB Office/Hospital Contact:	OB/Hospital Phone #:
Gravida/Para/AB/Living:	OB/Hospital Fax #:
Date of Hospital Admission (Mom):	Room #:
Delivery Date: _____ Gestation at Delivery: _____ Weeks Delivered on CCHP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OON	Delivery Type: <input type="checkbox"/> SVD <input type="checkbox"/> 1 st C/S <input type="checkbox"/> VBAC <input type="checkbox"/> R C/S <input type="checkbox"/> Other _____ If C/S, Reason: _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Hermaphrodite <i>[Multiple Births: A: <input type="checkbox"/> M <input type="checkbox"/> F, B: <input type="checkbox"/> M <input type="checkbox"/> F, C: <input type="checkbox"/> M <input type="checkbox"/> F]</i> Birth Weight ____ # ____ oz (gms) Apgars ____+____ Length/Height ____ in (____ cms) Baby Name(s): _____	Baby Feeding: <input type="checkbox"/> Breast feeding <input type="checkbox"/> Breast and Bottle <input type="checkbox"/> Bottle <input type="checkbox"/> NG Tube Fed <input type="checkbox"/> G-Button Fed Formula Name: _____ Baby PCP: _____
Delivery/Birth Complications:	
MOM: <input type="checkbox"/> NONE <input type="checkbox"/> Bleeding <input type="checkbox"/> Eclampsia <input type="checkbox"/> Gestational DM <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> Infection-gbs/HIV <input type="checkbox"/> Late Prenatal Care <input type="checkbox"/> Maternal ICU <input type="checkbox"/> Maternal Death <input type="checkbox"/> No Prenatal Care <input type="checkbox"/> Premature Rupture Membranes <input type="checkbox"/> Preterm Delivery <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> STDs/Herpes <input type="checkbox"/> UTI(s) <input type="checkbox"/> OTHER: _____	
BABY: <input type="checkbox"/> NONE <input type="checkbox"/> Baby adopted out <input type="checkbox"/> Birth Defect(s) <input type="checkbox"/> BPD <input type="checkbox"/> Erythroblastosis Fetalis <input type="checkbox"/> Heart Problem <input type="checkbox"/> Hyperbilirubinemia/Jaundice <input type="checkbox"/> Hypoglycemia (low BS) <input type="checkbox"/> Hypothermia <input type="checkbox"/> Infant Death <input type="checkbox"/> IUGR <input type="checkbox"/> Low Birth Weight Baby <input type="checkbox"/> Premature Baby <input type="checkbox"/> MRSA <input type="checkbox"/> Multiple Birth <input type="checkbox"/> NEC <input type="checkbox"/> Neonatal Death <input type="checkbox"/> NICU <input type="checkbox"/> Quadruplets <input type="checkbox"/> Quintuplets <input type="checkbox"/> RDS <input type="checkbox"/> Retrolental Fibroplasia <input type="checkbox"/> SAB/Fetal Loss/Miscarriage <input type="checkbox"/> Seizures <input type="checkbox"/> Triplets <input type="checkbox"/> Twins <input type="checkbox"/> Very Low Birth Weight Baby <input type="checkbox"/> OTHER: _____	
Date of Hospital Discharge (Mom): _____	LOS: ____ Days
Baby home with mom? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Appointment Dates: Mom: _____ Baby: _____	Medications:
Home Health: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, HH Vendor Name: _____	Mom: _____ Baby: _____

Inpatient/Delivery Authorization Number: _____

Nursery/NICU Authorization Number: _____

**SPECIALIST AS A
PRIMARY CARE PHYSICIAN AGREEMENT**

THIS SPECIALIST AS A PRIMARY CARE PHYSICIAN SERVICES AGREEMENT ("Agreement") is made as of this ___ day of _____, 20__ ("Effective Date"), by and between Cook Children's Health Plan ("CCHP"), and _____ ("Physician") to provide Primary Care Services for _____ ID # _____ ("Member").

Coordination of Care – It is the responsibility of Physician, as a Primary Care Provider, to coordinate all of the Member's Covered services, also to assist the Member in obtaining access to Covered services including authorizations or pre-certifications (as required), routine, urgent and emergent visits for general acute care. The expectations for primary care services include, but are not limited to, provision of all preventive health services, including immunizations, as specified by the CCHP Guidelines for Childhood Immunizations and Preventive Health Visits.

Accessibility Hours of Operation – Physician shall offer Members access to Covered services on a twenty-four (24) hour per day, seven (7) day per week basis. Such access shall include regular office hours on weekdays and availability by telephone outside of such regular hours, including weekdays and holidays.

Term – This Agreement shall be in effect unless CCHP or Physician notifies the other in writing at least thirty (30) days prior to the parties intent to terminate this agreement.

COOK CHILDREN'S HEALTH PLAN

PHYSICIAN

By: _____

By: _____

Print Name: Gregory Preston, MD

Print Name: _____

Title: Medical Director

Title: _____

Date: _____

Date: _____

AUTHORIZATION TO RELEASE INFORMATION

_____ requested access to information that LifeSynch (formerly Corphealth) maintains. Please fill this form out according to the instructions below and return it to the address at the bottom of the form.

Instructions

The authorization form gives LifeSynch permission to use or disclose your health information as directed.

The following information will help you fill out the form, however, if you have any questions with the information on this form please call (800) 777-6330 and a Customer Service Representative will direct your call to someone who is able to answer your questions.

1. Patient Information

The patient is the person who is giving permission to use or disclose their information. Please write the identifying information as requested, including name, address, date of birth, and telephone number. The patient identification (ID) number is also required and can be found on your health insurance card.

2. Information to be Released

You may select the information by marking one of the boxes and filling in the information requested as appropriate. In the first box, you may cross out information that you do not want to be disclosed. If there is a specific time frame that you would like information to be disclosed from, you may select the second box and fill in the timeframes of your choice. If you would like information from a specific provider to be used or disclosed, please check the second box.

Please include the name, address, and relationship of the person that you would like your information to be used or disclosed to.

Select a reason that the information will be disclosed. If LifeSynch requests the authorization for its own purposes, this section may already be filled in for you.

3. Notice to the Patient

Please read this section as it includes important information regarding your rights as a patient.

4. Signature

Please sign and date the authorization form. If the patient is unable to sign the form please have it signed by an authorized representative, such as a parent or power of attorney. Provide the relationship to the patient and include legal documentation that informs LifeSynch of the right to act for the patient.

AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION

ALL BOXES MUST BE FILLED OR FORM WILL NOT BE PROCESSED.

Patient Name:		Date of Birth:	
Street address:		Patient ID no. (found on insurance card):	Home phone no.: ()
P.O. box:	City:	State:	ZIP Code:

INFORMATION TO BE RELEASED

I authorize the use and/or disclosure of my protected health information by LifeSynch as described:

- My personal health information relating to my claims, benefits/eligibility, certification, complaint or appeal information (cross out any information that you do not wish to be disclosed).
- My health information from _____ to _____
- Information concerning my treatment with (provider name, location) _____
- Other (please be specific and include dates) _____

I authorize the selected information to be disclosed to the following person(s):

Name:	Relationship:
Address:	City, State, ZIP Code:
Name:	Relationship:
Address:	City, State, ZIP Code:

The reason this information will be used or disclosed:

- Coordination of Care
- Appeal or Complaint Process
- Legal Purposes
- Other _____

LifeSynch does not use patient information for marketing purposes.

NOTICE TO PATIENT

You may refuse to sign this form. You do not have to sign this form to receive services or treatment, except:

- If the only purpose for providing you with services is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive services.
- If services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to research related services and the use or disclosures will be limited to what is necessary for the research.

Under Federal law, you do not have to allow us to receive the private notes from your counseling sessions with a mental health professional. If your information is given to others as allowed in the form, Federal privacy laws may not protect it. Also, if you have allowed information to go to an insurance company to obtain coverage, the insurance company may still have the legal right to use the information.

You also have the right to revoke this authorization at anytime. In order to do so, you must do so in writing through the LifeSynch Privacy Office. A request to revoke an authorization will not affect any actions taken before LifeSynch receives the request. Unless otherwise revoked, this authorization will expire in 365 days from the date signed.

By signing below, I understand and affirm the statements included in this authorization form.

Signature of Patient or Legal Representative: _____	Date: _____
---	-------------

If signed by Legal Representative, please provide printed name and relationship/authority to Patient:

If signed by a legal representative, please provide legal documentation that proves such authority, i.e. Power of Attorney, Living Will, or Guardianship papers.

Please return form to:	LifeSynch Attn: Privacy Office 1300 Summit Ave, Suite 600 Fort Worth TX 76102	Or Fax to: (817) 335-9100
------------------------	--	---------------------------

All authorizations are subject to approval by LifeSynch.

A copy must be placed in patient file.